STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 an annual survey on December 30, 2025.	C 000		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 3 sampled residents (#2, and #3) completed a two-step tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: 1. Resident #2's current FL2 dated 08/06/25 revealed there was no documentation of diagnoses. Review of Resident #2's Resident Register revealed an admission date of 07/01/24. Review of Resident #2's record revealed: -There was documentation of one negative TB test completed on 06/30/24.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 202	Continued From page 1 -There was no documentation of a second TB skin test result. Refer to the Administrator's interview on 12/30/25 at 6:30pm. 2. Resident #3's current FL2 dated 10/16/24 revealed diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia. Review of Resident #3's Resident Register revealed an admission date of 09/05/25. Review of Resident #3's record revealed: -There was documentation from a primary care physician's office of one negative TB test completed on 08/21/25. -There was no documentation of a second TB skin test result. Refer to the interview with Administrator on 12/30/25 at 6:30pm. _____ Interview with the Administrator on 12/30/25 at 6:30pm revealed: -She was responsible for ensuring residents had completed TB testing on admission to the facility with documentation in each of the residents' records. -She did not realize Resident #2 and #3 were missing their second TB results and not available.	C 202		
C 206	10A NCAC 13G .0702 (e) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (e) The result of the medical examination	C 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 206	Continued From page 2	C 206		

required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following:
(1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care;
(2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset;
(3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status including orders for therapeutic diets;
(4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints;
(5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication;
(6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and
(7) additional information as determined by the physician or physician extender to be necessary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 206	Continued From page 3 for the care of the resident.	C 206		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, & #3) had an FL2 that included their diagnoses (#1 and #2) and admitting patient information (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 08/06/25 revealed:
-There was no documentation of Resident #1's diagnoses.
-Resident #1 was ambulatory.
-Resident #1's level of care was assisted living.

Review of Resident #1's Resident Register revealed an admission date of 08/01/24.

Review of Resident #1's record revealed there was no documentation of an updated FL2 dated after 08/06/25 that revealed Resident #1's current diagnoses.

Refer to the interview with the Administrator on 12/30/25 at 6:30pm.

2. Review of Resident #2's current FL2 dated 08/06/25 revealed:
-There was no documentation of Resident #2's diagnoses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 206	Continued From page 4 -Resident #2 was semi-ambulatory. -Resident #2's level of care was assisted living. Refer to the interview with the Administrator on 12/30/25 at 6:30pm. 3. Review of Resident #3's current FL2 dated 09/05/25 revealed: -Resident #3's diagnoses included acute kidney failure, congestive heart failure, hypertension, hyperglycemia and hyperlipidemia. -There was no documentation of the resident's current medical information, including orientation, behaviors, personal care assistance needs, ambulatory status, functional limitations, information related to activities and social needs, neurological status including orders for therapeutic diets. -Resident #3's level of care was assisted living. Refer to the interview with the Administrator on 12/30/25 at 6:30pm. _____ Interview with the Administrator on 12/30/25 at 6:30pm revealed: -She was responsible for reviewing the residents' FL2s to make sure they were complete. -If FL2s were incomplete, she was responsible for contacting the physician to get the FL2 updated. -She did not realize the FL2s for Residents #1, #2, and #3 were incomplete because she was fulfilling multiple roles at once.	C 206		
C 213	10A NCAC 13G .0704 (a)(1) Resident Contract, Information on Facility 10A NCAC 13G .0704 Resident Contract, Information on Facility, and Resident Register (a) The administrator or supervisor-in-charge	C 213		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 213	Continued From page 5	C 213		

shall furnish and review with the resident or the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given. This statement shall be retained in the resident's record in the facility. The information shall consist of the following:

(1) the resident contract to which the following applies:

(A) the contract shall specify charges for resident services and accommodations, including the cost of different levels of service, description of levels of care and services, and any other charges or fees;

(B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet;

(C) the contract shall be signed and dated by the administrator or supervisor-in-charge and the resident or the resident's authorized representative and a copy given to the resident or the resident's authorized representative and a copy kept in the resident's record;

(D) the resident or the resident's authorized representative shall be given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended copy of the contract for review and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 213	Continued From page 6	C 213		

confirmation of receipt;
(E) gratuities in addition to the established rates shall not be accepted; and
(F) The maximum monthly rate that may be charged to Special Assistance recipients as established by the North Carolina General Assembly;

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure the Resident Register was completed and signed by the family care home's Administrator or Supervisor-in-Charge within 72 hours of admission to the facility for 3 of 3 residents (#1, #2, and #3).

The findings are:

1. Review of Resident #1's current FL2 dated 08/06/25 revealed:
-There were no diagnoses documented.
-Resident #1 was ambulatory and his level of care was assisted living.

Review of Resident #1's Resident Register dated 07/31/24 revealed:
-Resident #1 had an admission date of 08/01/24.
-There was no documentation the Resident Register was signed or dated by the Administrator.

Refer to the interview with the Administrator on 12/30/25 at 6:30pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 213	Continued From page 7 2. Review of Resident #2's current FL2 dated 08/06/25 revealed: -There were no diagnoses documented. -Resident #2 was semi-ambulatory, and her level of care was assisted living. Review of Resident #2's Resident Register dated 07/01/24 revealed: -Resident #2 had an admission date of 07/01/24. -There was no documentation the Resident Register was signed or dated by the Administrator. Refer to the interview with the Administrator on 12/30/25 at 6:30pm. 3. Review of Resident #3's current FL2 dated 09/05/25 revealed: -Resident #3's diagnoses revealed acute kidney failure, congestive heart failure, hypertension, hyperglycemia and hyperlipidemia. -Resident #3's level of care was assisted living. Review of Resident #3's Resident Register dated 09/08/25 revealed: -Resident #3 had an admission date of 09/05/25. -There was no documentation the Resident Register was signed or dated by the Administrator. Refer to the interview with the Administrator on 12/30/25 at 6:30pm. _____ Interview with the Administrator on 12/30/25 at 6:30pm revealed: -She was responsible for ensuring the Resident Register and other admission documentation was completed accurately. -She overlooked the need to sign and date the Resident Registers for Resident #1, #2 and #3.	C 213		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure medication orders were maintained in the resident's record for 1 of 3 sampled residents (#2), related to an order change for a medication used to treat depression. The findings are: Review of Resident #2's current FL2 dated 08/06/25 revealed: -There were no diagnoses documented. -There was an order for escitalopram (to treat depression) 10mg one tablet daily. Review of October 2025, November 2025, and December 2025 MARs revealed: -There was an entry for escitalopram 20mg one tablet daily. -There was documentation escitalopram 20mg was administered from 10/20/25 to 10/31/25, November 2025 and December 2025. -There was no documentation escitalopram was administered 10/01/25 to 10/19/25. -There was no documentation of an order change from escitalopram 10mg, take one tablet by mouth daily to escitalopram 20mg, take one tablet by mouth daily. Review of Resident #2's record revealed there was no physician order for escitalopram 20mg, take one tablet by mouth daily.	C 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 316	Continued From page 9 Observation of Resident #2's medications available revealed there was escitalopram 20mg tablets available for administration. Interview with the administrator on 12/30/25 at 6:30pm revealed: -She was responsible for monitoring medication changes, physician orders and contacting the pharmacy about changes. -When a medication dose is changed by the physician, a signed order would have been placed on the resident's chart, the pharmacy would have been notified to generate an updated MAR to reflect the dosage change, then send it to the facility. -She was sure the pharmacy received the order for the increased dosage change because the MAR reflected the escitalopram 20mg instead of escitalopram 10mg. -She could not locate an updated physician's order change for escitalopram 10mg to escitalopram 20mg that would have been located on Resident #2's record.	C 316		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 10	C 342		

medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration record (MAR) were accurate for 3 of 3 sampled residents (#1, #2 & #3) related to medications that were administered but not documented on their MARs.

The findings are:

1.Review of Resident #1's current FL2 dated 08/06/25 revealed:
-There was no documentation of Resident #1's diagnoses.
-There were medication orders for citalopram 10mg (one tablet at bedtime), amlodipine besylate (one tablet daily) 5mg, hydrochlorothiazide 20mg (one tablet daily), Vitamin C 500mg (one tablet daily), aspirin 81mg(one tablet daily), atorvastatin calcium 20mg (one tablet daily), tamsulosin HCL .4mg (one tablet at bedtime), Vitamin D-3 25mcg (one tablet daily), Vitamin B-12 1000mcg (one tablet daily), finasteride 5mg (one tablet daily), montelukast 10mg (one tablet at bedtime), omega-3 fish oil 1200mcg (one tablet daily), Vitamin B-6 100mg (one tablet daily), trazadone 100mg (one tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 11 daily), donepezil HCL 5mg (one tablet daily), diclofenac sodium 1% (apply 2mg to wrist and finger), melatonin 5mg (one tablet daily at bedtime), quetiapine fumarate 100mg (one at bedtime), and quetiapine 50mg (one at bedtime). Review of physician medication orders dated 10/13/25 revealed: -There was an order for amlodipine (used to treat high blood pressure) 5mg, one tablet daily. -There was an order for citalopram (used to treat depression) 10mg, one tablet at bedtime. -There was an order for hydrochlorothiazide (used to treat high blood pressure) 25mg, one tablet daily. -There was an order for vitamin C 500mg, one tablet daily. -There was an order for aspirin 81mg, one tablet daily. -There was an order for atorvastatin calcium (used to treat high cholesterol) 20mg, one tablet daily. -There was an order for tamsulosin HCL (used to treat enlarged prostate) .4mg, one tablet at bedtime. -There was an order for vitamin D-3 25mcg, one tablet daily. -There was an order for vitamin B-12 1000mcg, one tablet daily. -There was an order for finasteride (used to treat enlarged prostate) 5mg, one tablet daily. -There was an order for montelukast (used to treat seasonal allergies) 10mg, one tablet at bedtime. -There was an order for omega 3 fish oil 1200mg, one tablet daily. -There was an order for vitamin B-6 100mg, one tablet daily. -There was an order for trazadone 150mg, one tablet at bedtime.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 12 -There was an order for donepezil HCL (used to treat dementia) 5mg, one tablet daily. - There was an order for diclofenac sodium (used to treat joint pain) 1%, apply 2mg to wrist and finger. -There was an order for melatonin (used to treat insomnia) 5mg, one tablet daily at bedtime. -There was an order for doxepin HCL (used to treat depression and anxiety)25mg, take three tablets at bedtime. -There was an order for alprazolam (used to treat anxiety) 1mg, one tablet at bedtime. -There was an order for quetiapine fumarate (used to treat psychosis) 100mg, one tablet at bedtime. -There was an order for quetiapine fumarate 50mg, one tablet at bedtime with 100mg. -There was an order for mirabegron ER (used to treat overactive bladder) 25mg, one tablet daily. -There was an order tab-a vite (multi-vitamin), one tablet daily. -There was an order for acetaminophen 500mg, two tablets twice daily. Review of Resident #1's October MAR revealed: -There was an entry for amlodipine (used to treat high blood pressure, 5mg, one tablet daily. -There was an entry for citalopram HBR (used to treat depression) 20mg, one tablet every morning. -There was an entry for hydrochlorothiazide (used to treat high blood pressure) 25mg, one tablet daily. -There was an entry for vitamin C 500mg, one tablet daily. -There was an entry for aspirin 81mg, one tablet daily. -There was an entry for atorvastatin (used to treat high cholesterol) 20mg, one tablet daily. -There was an entry for tamsulosin HCL (used to	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 13	C 342		

treat enlarged prostate) .4mg, one tablet at bedtime.
-There was an entry for vitamin D3 1000 unit tablet, one tablet daily.
-There was an entry for vitamin B-12 1000mcg, one tablet daily.
-There was an entry for nystatin-triamcinolone cream, apply one application topically to affected area two times a day as needed.
-There was an entry for montelukast (used to treat seasonal allergies) 10mg, one tablet at bedtime.
-There was an entry for Mirapex ER .375mg, take 3 tablets by mouth daily for five days, then take 2 tablets by mouth daily for five days, then take one tablet by mouth daily for five days, then stop.
-There was an entry for omega 3 fish oil 1200mg, one tablet daily.
-There was an entry for vitamin B-6 100mg, one tablet daily.
-There was an entry for vitamin B-6 100mg, one tablet daily.
-There was an entry for trazadone 150mg, one tablet at bedtime.
-There was an entry for donepezil HCL (used to treat dementia) 10mg, one tablet daily.
- There was an entry for diclofenac sodium (used to treat joint pain) 1%, apply 2mg to wrist and finger as needed for arthritis.
-There was an entry for doxepin HCL (used to treat depression and anxiety) 6mg, take three tablets at bedtime, Discontinued 10/28/25.
-There was an entry for alprazolam (used to treat anxiety) .25mg, one tablet by mouth three times daily (8:00am, 2:00pm and 8:00pm.)
-There was an entry for alprazolam (used to treat anxiety) .25mg, one tablet at bedtime as needed at 8:00pm.
-There was an entry for quetiapine fumarate (used to treat psychosis) 100mg, one tablet at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 14 bedtime. -There was an entry for quetiapine fumarate 50mg, one tablet at bedtime with 100mg. -There was an entry for mirabegron ER (used to treat overactive bladder) 25mg, one tablet daily. -There was an entry for tab-a vite (multi-vitamins), one tablet daily. -There was an entry for acetaminophen 500mg, two tablets twice daily. -There was no documentation Resident #1's medications were administered from 10/01/25 to 10/19/25. -There was documentation Resident #1's medications were administered from 10/20/25 to 10/31/25. Observation of Resident #1's medications on hand on 12/30/25 revealed: -Amlodipine 5mg, one tablet daily was available. -Citalopram HBR 20mg, one tablet every morning was available. -Hydrochlorothiazide 25mg, one tablet daily was available. -Vitamin C 500mg, one tablet daily was available. -Aspirin 81mg, one tablet daily was available. -Atorvastatin 20mg, one tablet daily was available. -Tamsulosin HCL .4mg, one tablet at bedtime was available. -Vitamin D3 25mcg, one tablet daily was available. -Vitamin B-12 1000mcg, one tablet daily was available. -Nystatin-triamcinolone cream, apply one application topically to affected area two times a day as needed was not available and needed to be reordered. -Montelukast 10mg, one tablet at bedtime was available. -Omega 3 fish oil 1200mg, one tablet daily, was	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 15	C 342		

available.
-Vitamin B-6 100mg, one tablet daily, was available.
-Trazadone 150mg, one tablet at bedtime, was available.
-Donepezil HCL 10mg, one tablet daily, was available.
-Diclofenac sodium 1%, apply 2mg to wrist and finger as needed for arthritis, was available.
-Doxepin 25mg, one tablet at bedtime, was available.
-Melatonin 5mg, one tablet daily at bedtime, was available.
-Alprazolam 1mg, one tablet by mouth three times daily (8:00am, 2:00pm and 8:00pm) was available.
-Alprazolam 1mg, one tablet at bedtime as needed at 8:00pm, was available.
-Quetiapine fumarate 100mg, one tablet at bedtime, was available.
-Mirabegron ER 25mg, one tablet daily, was available.
-Tab-a vite (multi-vitamins), one tablet daily, was not available and needed to be reordered.
-Acetaminophen 500mg, two tablets twice daily, was available.

Refer to the interview with a medication aide (MA) on 12/30/25 at 1:45pm.

Refer to the interview with the Administrator on 12/30/25 at 6:30pm.

2. Review of Resident #2's current FL2 dated 08/06/25 revealed:
-There was no documentation of Resident #2's diagnoses.
-There were medication orders for atorvastatin calcium 40mg, clopidogrel bisulfate 75mg, diltiazem HCL ER 360mg, escitalopram oxalate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 16 10mg, loratadine 10mg, losartan potassium 50mg, meclizine 12.5mg, mirtazapine 15mg, metoprolol succinate ER 25mg, olanzapine 2.5mg, potassium CL ER 10meq, tab-a-vite, torsemide 20mg, trazadone 100mg, vitamin D-3 1000 units, diclofenac sodium 1% gel, olopatadine HCL 1% and polyethylene glycol as needed. Review of physician orders dated 11/24/25 revealed: -There was an order for atorvastatin calcium (used to treat high cholesterol) 40mg, one tablet at bedtime. -There was an order for clopidogrel bisulfate (used to prevent blood clots) 75mg, one tablet daily. -There was an order for diltiazem HCL ER (used to treat high blood pressure) 360mg, one capsule daily. -There was an order for escitalopram oxalate (used to treat depression) 20mg, one tablet daily. -There was an order for losartan potassium (used to treat high blood pressure) 100mg one tablet daily. -There was an order for meclizine (used to treat nausea) 25mg, one tablet daily. -There was an order for mirtazapine (used to treat insomnia) 15mg, one tablet daily. -There was an order for metoprolol succinate ER (used to treat high blood pressure) 25mg, 3 tablets at bedtime. -There was an order for olanzapine (used to treat psychosis) 2.5mg, one tablet at bedtime. -There was an order for torsemide (used to treat fluid retention) 20mg, one tablet daily. -There was an order for trazadone (used to treat insomnia) 100mg, 1 ½ tablets at bedtime. -There was an order for vitamin D-3 1000 units, one tablet daily.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 17 -There was an order for Tylenol 500mg, one tablet as needed every 4 hours. -There was an order for loratadine (used to treat allergies) 10mg, one tablet daily. -There was an order for diclofenac sodium (used to treat arthritis) 1% gel, apply 2gm to left hip twice daily. -There was an order for senna-S (used to treat constipation) 50- 8.6mg, one tablet daily as needed. -There was an order for polyethylene glycol 3350 powder (used to treat constipation), mix 17gm in 8ounces of liquid and take by mouth daily as needed for constipation. -There was an order for tab-a-vite (multi-vitamin), one tablet daily. -There was an order for potassium chloride (used to treat low potassium levels) 10meq, one tablet twice daily. Review of Resident #2's October MAR revealed: -There was an entry for atorvastatin calcium 40mg, one tablet at bedtime. -There was an entry for clopidogrel bisulfate 75mg, one tablet daily. -There was an entry for diltiazem HCL ER 360mg, one capsule daily. -There was an entry for escitalopram oxalate 20mg, one tablet daily. -There was an entry for losartan potassium 100mg one tablet daily. -There was an entry for meclizine 25mg, one tablet daily. -There was an entry for mirtazapine 15mg, one tablet daily. -There was an entry for metoprolol succinate ER 25mg, 3 tablets at bedtime. -There was an enter for olanzapine 2.5mg, one tablet at bedtime. -There was an entry for torsemide 20mg, one	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 18	C 342		

tablet daily.
-There was an entry for trazadone 100mg, 1 ½ tablets at bedtime.
-There was an entry for vitamin D-3 1000 units, one tablet daily.
-There was an entry for Tylenol 500mg, one tablet as needed every 4 hours.
-There was an entry for loratadine 10mg, one tablet daily.
-There was an entry for diclofenac sodium 1% gel, apply 2gm to left hip twice daily.
-There was an entry for senna-S 50- 8.6mg, one tablet daily as needed.
-There was an entry for polyethylene glycol 3350 powder, mix 17gm in 8ounces of liquid and take by mouth daily as needed for constipation.
-There was an entry for tab-a-vite, one tablet daily.
-There was an entry for potassium chloride 10meq, one tablet twice daily.
-There was no documentation Resident #2's medications were administered from 10/01/25 to 10/19/25.
-There was documentation Resident #2's medications were administered 10/20/25-10/31/25.

Observation of Resident #2's medications on hand on 12/30/25 revealed:
-Atorvastatin calcium 40mg, one tablet at bedtime, was available.
-Clopidogrel bisulfate 75mg, one tablet daily, was available.
-Diltiazem HCL ER 360mg, one capsule daily, was available.
-Escitalopram oxalate 20mg, one tablet daily, was available.
-Losartan potassium 100mg one tablet daily, was available.
-Meclizine 25mg, one tablet daily, was available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 19 -Mirtazapine 15mg, one tablet daily, was available. -Metoprolol succinate ER 25mg, 3 tablets at bedtime, was available. -Olanzapine 2.5mg, one tablet at bedtime, was available. -Torsemide 20mg, one tablet daily, was available. -Trazadone 100mg, 1 ½ tablets at bedtime, was available. -Vitamin D-3 1000 units, one tablet daily, was available. -Tylenol 500mg, one tablet as needed every 4 hours, was available. -Loratadine 10mg, one tablet daily, was available. -Diclofenac sodium 1% gel, apply 2gm to left hip twice daily, was available. -Senna-S 50- 8.6mg, one tablet daily as needed, was available. -Polyethylene glycol 3350 powder, mix 17gm in 8ounces of liquid and take by mouth daily as needed for constipation, was available. -There was an entry for tab-a-vite, one tablet daily. -There was an entry for potassium chloride 10meq, one tablet twice daily. Refer to the interview with a MA on 12/30/25 at 1:45pm. Refer to the interview with the Administrator on 12/30/25 at 6:30pm. 3. Review of Resident #3's current FL2 dated 09/05/25 revealed: -Resident #3's diagnoses revealed acute kidney failure, congestive heart failure, hypertension, hyperglycemia and hyperlipidemia. -There were medication orders for donepezil 10mg, amiodarone 100mg, amlodipine 5mg, atorvastatin 40mg, benzonatate 200mg, calcium	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 20 carbonate 500mg, clopidogrel 75mg, furosemide 20mg, and eye multivitamin 17mg. Review physician's orders for medications dated 10/14/25 revealed: -There was an order for donepezil HCL (used to treat dementia) 10mg, one tablet daily. There was an order for amiodarone (used to treat irregular heartbeat) 100mg, one tablet daily. -There was an order for amlodipine (used to treat high blood pressure) 5mg, one tablet daily. -There was an order for atorvastatin (used to treat high cholesterol) 40mg, one tablet daily. -There was an order for benzonatate (used to relieve a cough) 200mg, one tablet daily as needed. -There was an order for calcium carbonate (used for bone strength) 500mg, one tablet daily. -There was an order for clopidogrel (used to prevent blood clots) 75mg, one tablet daily. -There was an order for furosemide (used to fluid retention) 40mg, one tablet daily. Review of Resident #3's October MAR revealed: -There was an entry for donepezil 10mg, one tablet daily. -There was an entry for amiodarone 100mg, one tablet daily. -There was an entry for amlodipine 5mg, one tablet daily. -There was an entry for atorvastatin 40mg, one tablet daily. -There was an entry for benzonatate 200mg, one tablet daily as needed. -There was an entry for calcium carbonate 500mg, one tablet daily. -There was an entry for clopidogrel 75mg, one tablet daily. -There was an entry for furosemide 40mg, one tablet daily.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 21 -There was no documentation Resident #2's medications were administered from 10/01/25 to 10/19/25. -There was documentation Resident #3's medications were administered 10/20/25-10/31/25. Observation of Resident #3's medications on hand on 12/30/25 revealed: -Donepezil 10mg, one tablet daily was available. -Amiodarone 100mg, one tablet daily, was available. -Amlodipine 5mg, one tablet daily, was available. -Atorvastatin 40mg, one tablet daily, was available. -Benzonatate 200mg, one tablet daily as needed. -Calcium carbonate 500mg, one tablet daily, was available. -Clopidogrel 75mg, one tablet daily, was available. -Furosemide 40mg, one tablet daily, was available. -Eye multi-vitamin 174mg, one tablet twice daily, was available. Refer to the interview with a MA on 12/30/25 at 1:45pm. Refer to the interview with the Administrator on 12/30/25 at 6:30pm. _____ Interview with a MA on 12/30/25 at 1:45pm revealed: -She always documented administration of all resident medications. -She could not locate Resident #1, #2, and #3's MARs from 10/01/25 to 10/19/25 in the facility. Interview with the Administrator on 12/30/25 at 6:30pm revealed:	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060162	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR LIVING	16627 RANGER TRAIL HUNTERSVILLE, NC 28078

(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 342	Continued From page 22 -She was responsible for ensuring all resident MARs were available and maintained on resident's records. -MAs were responsible for documenting medication administration on resident MARs after they administered medications. -Resident MARs were not electronic and she did not maintain additional copies of MARs in the facility. -Resident MARs were maintained on their chart for the current month while older completed MARs were stored in the facility. -She could not locate documentation for Resident #1, #2, and #3's MARs dated 10/01/25 to 10/19/25 in the facility. Attempted telephone interview with the Primary Care Provider was unsuccessful.	C 342		