Division of Health Service Regulation

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 _____	C 07/16/2026

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 an annual survey on 07/15/26-07/16/26.	C 000	Management acknowledge that Joyful Home did not have a current fire inspection report available for review. Management held a meeting with staff to go over this and figure out how to fix it. As a result, the Administrator called the local Fire Marshal on 07/15/26 and got the inspection done on 07/16/26. We also set up electronic reminders so we don't miss scheduling the yearly fire inspection again.	7/18/26
C 034	10A NCAC 13G .0302 (n) Design and Construction 10A NCAC 13G .0302 Design and Construction (n) The facility shall maintain and have available for review current sanitation and fire safety inspection reports. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have a current fire inspection available for review. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire inspection report dated 04/14/25 revealed: -The facility passed the inspection. -There were no violations. Telephone interview with the receptionist at the local Fire Marshal's office on 07/15/26 at 9:44am revealed: -The facility had to call them and let them know when they needed a fire inspection. -The Fire Marshal would "usually" go "right out" when he knew someone needed a fire inspection.	C 034		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alex Dinoe Ashley

TITLE: Administrator

(X6) DATE: 7/23/2026

Reviewed and Acknowledged
Date: 07/28/26 CS

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C 034	Continued From page 1 Telephone interview with the local Fire Marshal on 07/15/26 at 9:55am revealed: -The facility was responsible for letting him know when they needed a fire inspection. -The facility staff had not called to request a fire inspection this year. Interview with the Administrator on 07/16/26 at 10:55am revealed: -He had contacted the local Fire Marshal yesterday (07/15/26) to request a fire inspection. -The Fire Marshal was coming out to the facility to do an inspection "today" (07/16/26). -He was setting up electronic reminders to ensure he scheduled annual fire inspections when they were due.	C 034	The Management of Joyful Home Family Care did acknowledge that orders on the 04/27/26 FL2 went to the contracted pharmacy, then to the backup pharmacy, which filled 30 tablets of each medication on 04/28/26. Those meds sat for 14 days and were returned to stock. Staff were never notified, and the mental health provider only sent the FL2 to the pharmacy without telling the facility. Resident #3 came in around 04/23/26… (timeline of FL2s, injectable history, ~ 25-day coverage, no hallucinations reported) The April eMAR showed zero doses… (including the odd "patch not on resident" note), May was 25 of 27, Administrator was never told, resident said it took about a week, therapeutic leave tablets ran out… Then the corrective steps in natural language:	7/30/26
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #3) related to a medication used to treat schizoaffective disorder and dementia.	C 330		

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C 330	Continued From page 2 The findings are: Review of Resident #3's current FL2 dated 05/06/26 revealed diagnoses included dementia, schizoaffective disorder, mental disorder, and generalized anxiety disorder. 1. Review of Resident #3's admission FL2 dated 04/23/26 revealed there was no order for paliperidone. Review of Resident #3's FL2 dated 04/27/26 revealed there was an order for paliperidone (used to treat schizoaffective disorder) ER 9mg one tablet daily. Review of Resident #3's current FL2 dated 05/06/26 revealed there was an order for paliperidone ER 9mg one tablet daily. Review of Resident #3's April 2026 electronic Medication Administration Record (eMAR) from 04/23/26-04/30/26 revealed: -There was an entry for paliperidone ER 9mg one tablet daily scheduled at 8:00am with a start date of 04/27/26. -There were no documented administrations of paliperidone from 04/27/26-04/30/26. -The paliperidone ER 9mg was documented as not administered on 04/29/26 due to "not received from drug store" and on 04/30/26 due to "patch not on resident". Review of Resident #3's May 2026 eMAR revealed: -There was an entry for paliperidone ER 9mg one tablet daily scheduled at 8:00am. -The paliperidone was documented as administered 25 occurrences out of 27 opportunities.	C 330	Same-day call to contracted pharmacy / backup pharmacy, pickup within 24 hours Written pharmacy contact log until meds are in the med room New medication receipt checklist (with all the fields you listed) Same-day FL2-vs-meds check on every new admission and every new FL2 Weekly eMAR review for "not administered / not received / blank" with same-day investigation Staff training; no more vague notes like "patch not on resident" for tablets Survey-day bubble packs already correct for June/July	7/30/26

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C 330	Continued From page 3 -The paliperidone was documented as not administered on 05/04/26 due to "not received from drug store." Review of Resident #3's June 2026 eMAR revealed: -There was an entry for paliperidone ER 9mg one tablet daily scheduled at 8:00am. -The paliperdone was documented as administered as ordered. Review of Resident #3's July 2026 eMAR from 07/01/26-07/15/26 revealed: -There was an entry for paliperidone ER 9mg one tablet daily scheduled at 8:00am. -The paliperdone was documented as administered as ordered. Observation of Resident #3's medications on hand on 07/16/26 at 9:29am revealed: -There was one bubble pack of paliperidone ER 9mg tablets with 13 tablets remaining with a dispense date of 07/01/26. -The label directions were paliperidone ER 9mg one tablet daily. Review of Resident #3's former facility therapeutic leave form dated 04/23/26 revealed there were eight tablets of paliperidone ER 9mg released to Resident #3 upon discharge. Review of the facility's medication checklist dated 05/20/26 revealed 30 tablets of paliperidone 5mg were delivered from the contracted facility pharmacy for Resident #3. Telephone interview with the facility's contracted pharmacy on 07/16/26 at 8:32am revealed: -On 04/23/26, they received an FL2 dated 04/23/26 for Resident #3, but the FL2 did not	C 330	Ongoing prevention: Checklist + contact log for every order, no exceptions Weekly + monthly review by Manager /Administrator Injectable-to-oral switches treated as high priority New staff trained before working alone Process reviewed at regular management meetings	7/30/26

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C 330	Continued From page 4 have an order for paliperidone. -On 04/27/26, they received an FL2 dated 04/27/26 for Resident #3 with an order for paliperidone ER 9mg one tablet daily. -The paliperidone ER 9mg was sent to a local backup pharmacy to be filled since it was outside their scheduled delivery date. Telephone interview with the facility's local backup pharmacy on 07/16/26 at 9:06am revealed: -They received an order for paliperidone ER 9mg one tablet daily on 04/28/26. -They filled 30 tablets of paliperidone ER 9mg on 04/28/26. -The paliperidone ER 9mg was never picked up. -The paliperidone ER 9mg was held for 14 days and then returned to stock because it was not picked up. Interview with the Resident Care Coordinator (RCC) on 07/16/26 at 9:00am revealed: -He was unaware the paliperidone ER 9mg tablets were available for pickup at the local backup pharmacy. -The mental health provider (MHP) did not communicate with the facility staff when they created a new FL2 for Resident #3 on 04/27/26. -That was why he asked Resident #3's primary care provider (PCP) to complete a new FL2 on 05/06/26. -The MHP only sent Resident #3's FL2 dated 04/27/26 to the facility's contracted pharmacy. -The facility's contracted pharmacy then notified the local backup pharmacy to fill the paliperidone ER 9mg. -The backup pharmacy did not notify the facility staff the paliperidone ER 9mg was ready for pick up for Resident #3.	C 330		

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C 330	Continued From page 5 Telephone interview with Resident #3's MHP on 07/15/26 at 4:50pm revealed: -The paliperidone was prescribed to treat schizoaffective disorder. -Resident #3 received an injectable version of the paliperidone for more than a year. -The injectable paliperidone was recently stopped at the request of Resident #3. -The injectable paliperidone would have continued to provide coverage for 25 days. -Missing doses of the oral form of paliperidone could potentially cause Resident #3 to experience auditory hallucinations after the injectable began to wear off. Interview with Resident #3 on 07/16/26 at 10:00am revealed she did not experience any unusual symptoms like auditory hallucinations as a result of the missed doses of paliperidone in April or May 2026. Refer to the interview with Resident #3 on 07/15/26 at 9:25am. Refer to the interview with the Administrator on 07/16/26 at 10:55am. 2. Review of Resident #3's admission FL2 dated 04/23/26 revealed there was no order for memantine. Review of Resident #3's FL2 dated 04/27/26 revealed there was an order for memantine (used to treat moderate to severe dementia associated with Alzheimer's disease) 5mg one tablet daily. Review of Resident #3's current FL2 dated 05/06/26 revealed there was an order for memantine 5mg one tablet daily.	C 330		

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C 330	Continued From page 6 Review of Resident #3's April 2026 electronic Medication Administration Record (eMAR) from 04/23/26-04/30/26 revealed: -There was an entry for memantine 5mg one tablet daily scheduled at 8:00am with a start date of 04/27/26. -There were no documented administrations of memantine from 04/27/26-04/30/26. -The memantine 5mg was documented as not administered on 04/29/26 due to "not received from drug store" and on 04/30/26 due to "patch not on resident". Review of Resident #3's May 2026 eMAR revealed: -There was an entry for memantine 5mg one tablet daily scheduled at 8:00am. -The memantine was documented as administered 25 occurrences out of 27 opportunities. -The memantine was documented as not administered on 05/01/26 and 05/02/26 due to "not received from drug store." -Resident #3 was documented as "out of facility" from 05/08/26-05/12/26. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for memantine 5mg one tablet daily scheduled at 8:00am. -The memantine was documented as administered as ordered. Review of Resident #3's July 2026 eMAR from 07/01/26-07/15/26 revealed: -There was an entry for memantine 5mg one tablet daily scheduled at 8:00am. -The memantine was documented as administered as ordered.	C 330		

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C 330	Continued From page 7 Observation of Resident #3's medications on hand on 07/16/26 at 9:29am revealed: -There was one bubble pack of memantine 5mg tablets with 13 tablets remaining with a dispense date of 07/01/26. -The label directions were memantine 5mg one tablet daily. Review of Resident #3's former facility therapeutic leave form dated 04/23/26 revealed there were eight tablets of memantine 5mg released to Resident #3 upon discharge. Review of the facility's medication checklist dated 05/20/26 revealed 30 tablets of memantine 5mg were delivered from the contracted facility pharmacy for Resident #3. Telephone interview with the facility's contracted pharmacy on 07/16/26 at 8:32am revealed: -On 04/23/26, they received an FL2 dated 04/23/26 for Resident #3, but the FL2 did not have an order for memantine. -On 04/27/26, they received an FL2 dated 04/27/26 for Resident #3 with an order for memantine 5mg one tablet daily. -The memantine 5mg was sent to a local backup pharmacy to be filled since it was outside their scheduled delivery date. Telephone interview with the facility's local backup pharmacy on 07/16/26 at 9:06am revealed: -They received an order for memantine 5mg one tablet daily on 04/28/26. -They filled 30 tablets of memantine 5mg on 04/28/26. -The memantine 5mg was never picked up. -The memantine 5mg was held for 14 days and then returned to stock because it was not picked	C 330		

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C 330	Continued From page 8 up. Interview with the Resident Care Coordinator (RCC) on 07/16/26 at 9:00am revealed: -He was unaware the memantine 5mg tablets were available for pickup at the local backup pharmacy. -The mental health provider (MHP) did not communicate with the facility staff when they created a new FL2 for Resident #3 on 04/27/26. -That was why he asked Resident #3's primary care provider (PCP) to complete a new FL2 on 05/06/26. -The MHP only sent Resident #3's FL2 dated 04/27/26 to the facility's contracted pharmacy. -The facility's contracted pharmacy then notified the local backup pharmacy to fill the memantine 5mg. -The backup pharmacy did not notify the facility staff the memantine 5mg was ready for pick up for Resident #3. Telephone interview with Resident #3's MHP on 07/15/26 at 4:50pm revealed: -The memantine was prescribed to treat dementia. -The memantine did not help Resident #3. -She and Resident #3 had discussed discontinuing the memantine. Interview with Resident #3 on 07/16/26 at 10:00am revealed she did not experience any unusual symptoms as a result of the missed doses of memantine April or May 2026. Refer to the interview with Resident #3 on 07/15/26 at 9:25am. Refer to the interview with the Administrator on 07/16/26 at 10:55am.	C 330		

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C 330	Continued From page 9 Interview with Resident #3 on 07/15/26 at 9:25am revealed: -She had lived at the facility for three months. -She ran out of one of her medications "a month ago." -She did not remember the name of the medication. -It took the facility stafff "a week" to get her medication. Interview with the Administrator 07/16/26 at 10:55am revealed: -He was made aware when Resident #3 was admitted to the facility and she did not have physician orders for all the medications that arrived with the resident. -He was not made aware Resident #3's medications for the FL2 written 04/27/26 were not received from the pharmacy.	C 330		