ND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		PLETED
		A. BUILDING: _		R 03/29/2 DRRECTION N SHOULD BE E APPROPRIATE	R
	MHL032-389	B. WING			29/2018
AME OF PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ESTINY HOME, INC		PLING STREAN /I, NC 27704	I ROAD		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000 INITIAL COMMENTS	6	V 000			
	/ up survey was completed Deficiencies were cited.				
	d for the following service 27 G .5600A Supervised Mental Illness				
V 107 27G .0202 (A-E) Per	sonnel Requirements	V 107			
which: (1) specifies the competency, work ex- qualifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained ir (b) All facilities shall each staff member of provides care or serventhe facility: (1) is at least 18 (2) is able to read follow directions; (3) meets the m	have a written job rector and each staff position e minimum level of education experience and other position; e duties and responsibilities of the staff member and the n the staff member's file. ensure that the director, or any other person who vices to clients on behalf of 8 years of age; ad, write, understand and inimum level of education, experience, skills and other	,			
(4) has no subs neglect listed on the Personnel Registry.(c) All facilities or se applicants for employ conviction. The important	tantiated findings of abuse of North Carolina Health Care ervices shall require that all yment disclose any criminal act of this information on a mployment shall be based				

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

	of Health Service Re					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		MHL032-389	B. WING			R 29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
DESTIN	Y HOME, INC		PLING STREAM 1, NC 27704	MROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
V 107	upon the offense in which the applicant (d) Staff of a facility currently licensed, r accordance with ap services provided. (e) A file shall be m employed indicating	relationship to the job for is applying. y or a service shall be registered or certified in plicable state laws for the naintained for each individual g the training, experience and for the position, including	V 107			
	facility failed to have affecting three of th	et as evidenced by: views and interview, the e a complete personnel record ree audited staff (The nal, staff #1 and staff #2). The				
	3/29/18 revealed: -The Qualified Profe 3/3/17.	cility's personnel records on essional had a hire date of umentation of a job description ofessional.				
	3/29/18 revealed: -Staff #1 had a hire -Staff #1 was hired	cility's personnel records on date of 2/1/10. as a Personal Care Assistant. umentation of a job description				

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:			COM	PLETED
		MHL032-389	B. WING			R 29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
DESTIN	Y HOME, INC		LING STREAN , NC 27704	I ROAD		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 107	Continued From pa	ge 2	V 107			
	3/29/18 revealed: -Staff #2 had a hire -Staff #2 was hired -There was no docu for staff #2. Interview on 3/29/18 -There were no job Professional, staff #	as a Personal Care Assistant. Imentation of a job description 8 with the Director confirmed: descriptions for the Qualified 41 and staff #2. stitutes a re-cited deficiency				
V 108	3 27G .0202 (F-I) Per	sonnel Requirements	V 108			
	 (g) Employee trainip provided and, at a r following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathoge (h) Except as permined to the shall be available to the shall be available to the shall be training seizure m to provide cardiopulation 	ation shall be documented. ng programs shall be ninimum, shall consist of the ational orientation; nt rights and confidentiality as CAC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the n the treatment/habilitation tious diseases and				

STATEME	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		MHL032-389	B. WING			R 29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DESTIN	Y HOME, INC		PLING STREAN /I, NC 27704	/I ROAD		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 108	Continued From pa	ge 3	V 108			
	the American Heart equivalence for relia (i) The governing b implement policies reporting, investigat	those provided by Red Cross Association or their eving airway obstruction. ody shall develop and and procedures for identifying ing and controlling infectious diseases of personnel and				
	failed to ensure staf mh/dd/sa (mental h disability/substance specified in the trea	et as evidenced by: view and interviews the facility f had training to meet the ealth/developmental abuse) needs of the client as tment/habilitation plan ee audited staff (staff #2). The				
	3/29/18 revealed: -Staff #2 had a hire -Staff #2 was hired -There was no docu training to meet the	y's personnel records on date of 3/1/18. as a Personal Care Assistant. imentation staff #2 had mh/dd/sa needs of the client reatment/habilitation plan.				
	3/29/18 revealed: -She had not done t #2. -She would be doing next week when he -She confirmed staf	the mh/dd/sa training for staff g staff #2's training within the returns to the group home. If #2 had no training to meet of the client as specified in tation plan.				

Division	of Health Service Re	equiation			FURM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL032-389	B. WING			R 29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	HOME, INC	630 RIPP	LING STREAM	MROAD		
DEOTIN		DURHAN	I, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 4	V 108			
	-Staff #2 had no tra needs of the client a treatment/habilitatio	on plan. stitutes a re-cited deficiency				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified i of this Rule shall be enable staff to resp needs. (b) A minimum of c present at all times premises, except w habilitation plan doo capable of remainir without supervision as needed but not li the client continues the home or common specified periods of (c) Staff shall be pr following client-staff child or adolescent (1) children o abuse disorders sha of one staff present clients present. Ho present during slee emergency back-up the governing body (2) children o developmental disa	bes above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ng in the home or community . The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for f time. resent in a facility in the f ratios when more than one client is present: r adolescents with substance all be served with a minimum f or every five or fewer minor owever, only one staff need be ping hours if specified by the o procedures determined by				

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL032-389	B. WING			R 29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	-	
			LING STREAM			
DESTIN	Y HOME, INC	DURHAN	I, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From pa	ge 5	V 290			
	more clients preser need be present du specified by the em determined by the g (d) In facilities which diagnosis is substa (1) at least or duty shall be trained withdrawal symptor secondary complicat drug addiction; and (2) the service	ch serve clients whose primary nce abuse dependency: ne staff member who is on d in alcohol and other drug ns and symptoms of ations to alcohol and other d es of a certified substance nall be available on an	,			
	interviews, the facili capability of having community without of three audited clie Observation of facil AM and 1:30 PM re -Client #1 was away	on, record review and ity failed to assess a client's unsupervised time in the staff supervision affecting one ents (#1). The findings are: ity on 3/29/18 between 10:40				
	-Admission date of -Diagnosis of Schiz -There was no docu been assessed for	ophrenia-Paranoid Type. umentation that client #1 had				

Division	of Health Service Re	gulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL032-389	B. WING			R 29/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
DESTIN	Y HOME, INC		LING STREAN , NC 27704	M ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 290	Continued From pa	ge 6	V 290			
	-Client #1 was allow in the community. -Client #1 normally -He would normally area. -Client #1 takes the -She confirmed the	#1 on 3/28/18 revealed: wed to have unsupervised time goes to visit his family. walk to the bus stop in the local bus to visit his family. facility failed to assess client wing unsupervised time in the				
	the community with -Client #1 would no to visit his family. -It just recently cam #1 was walking to th -Client #1 was not h to his issues with di -She confirmed the	ed: using unsupervised time in out staff. rmally catch the bus in order the to her attention that client he store unsupervised. having unsupervised time due				
	-The facility failed to	irector on 3/29/18 confirmed: assess client #1's capability ised time in the community.				
	This deficiency con- and must be correc	stitutes a re-cited deficiency ted within 30 days.				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				

Division of Health Service Regulation STATE FORM

5V8K11

If continuation sheet 7 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
			A. BUILDING.			R
		MHL032-389	B. WING			29/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DESTINY	HOME, INC		PLING STREAM 1, NC 27704	MROAD		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE ⁻ DATE
V 736	Continued From pa	ige 7	V 736			
	odor.					
	This Rule is not me					
	failed to ensure fac	ion and interviews, the facility ility grounds were maintained				
	The findings are:	ractive and orderly manner.				
		8/18 at approximately 1:20 PM yard area revealed the				
	-There were pieces mop bucket, approx	of trash, a door, car battery, ximately ten wooden crates, a air, approximately five paint				
	cans, approximatel weed eater and a n	y four plastic containers, a				
	linoleum, a hand he water hose, hedge	eld gardening tool, a hoe, clippers, a rake, a shovel,				
		rs, leaves, approximately three mately three plastic containers				
	-The grass and we inches long.	eds were approximately six				
	- I here was a plasti ten wooden stakes	c container with approximately in it.	,			
	-A former staff was	#1 on 3/28/18 revealed: doing some gardening in the				
		ft the group home and failed ng tools/items with him.				
	-She thought that for in January 2018.	ormer staff left the group home	•			
		facility was not maintained in ctive and orderly manner.				
	Interview with the D	Director on 3/28/18 confirmed:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL032-389	B. WING			R 29/2018
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ESTINY	HOME, INC		PLING STREAN M, NC 27704	I ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
V 736	Continued From pa	age 8	V 736			
	-The facility was no attractive and order	nt maintained in a safe, clean, rly manner.				