STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-759	B. WING	WING		01/16/2020	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2020	
ESTINY	FAMILY CARE HOM		LENDALE DRIV H, NC 27604	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual and follow-up survey was completed January 16, 2020. Deficiencies were cited.						
	The facility is licensed for the following service category: 10A NCAC 27G .5600 A Supervised Living for Adults with Mental Illness.						
V 114	27G .0207 Emergency Plans and Supplies		V 114				
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved b authority. (b) The plan shall b and evacuation pro posted in the facility (c) Fire and disaster shall be held at lease repeated for each s under conditions th	207 EMERGENCY PLANS in for each facility and plan shall be developed and by the appropriate local we made available to all staff cedures and routes shall be y. er drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies					
	failed to assure fire	et as evidenced by: view and interview, the facility and disaster drills were quarterly on each shift. The					
		20 of facility records revealed eted 1/1/19 thru 1/13/20.					
	During interview on -the staff had n	01/13/20, client #2 reported:					

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	of Health Service Re		0.00		, =	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	MHL092-75		B. WING		01/16/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DESTIN	Y FAMILY CARE HOM	F	LENDALE DRIV H, NC 27604	VE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETE DATE
V 114	Continued From pa	age 1	V 114			
	drills "in a long time	9".				
	During interview on 01/13/20, the Qualified Professional reported: -drills should be ran one per shift quarterly. -a change in staff may be why drills aren't current.					
		0 of the facility's records saster drills completed 3/20.				
		completed on 8/29/19 @ /20/19 @ 8:00am disaster and disaster.				
		01/13/20, client #2 reported: tot conducted fire or disaster "				
	Professional report -drills should be	01/13/20, the Qualified ed: e ran one per shift quarterly. aff may be why drills aren't				
V 118	27G .0209 (C) Mec	lication Requirements	V 118			
	only be administered order of a person a drugs. (2) Medications sha clients only when a client's physician.					

Division of Health Service Regulation STATE FORM

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If continuation sheet 2 of 5

		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-759	B. WING		01/	16/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	FAMILY CARE HOM	- 3509 ALI		VE		
		E RALEIGI	H, NC 27604			
(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 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 118	Continued From pa	age 2	V 118			
	unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ac all drugs administe current. Medication recorded immediate MAR is to include ti (A) client's name; (B) name, strength (C) instructions for (D) date and time ti (E) name or initials drug. (5) Client requests checks shall be reco	by licensed persons, or by strained by a registered nurse, r legally qualified person and re and administer medications. dministration Record (MAR) of red to each client must be kep as administered shall be ely after administration. The he following: , and quantity of the drug; administering the drug; he drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
	Based on record re failed to keep MAR immediately after a clients (#2). The fin	0 of client #2's record	1			
	-Diagnoses of Schi Disability Mild -Physician's order v 50mg-use 1-2 spra used to treat seaso Toriaz 4mg take on	izophrenia, Intellectual written 12-5-19 -fluticasone lys in each nositril everyday onal and year round allergies, le tablet by mouth every day to ldder, cetirizine 10mg take one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL092-759	B. WING		01/16/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DESTINY	FAMILY CARE HOM	F	LENDALE DRIV H, NC 27604	VE.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ige 3	V 118			
	inject 80units every type 2 diabetes in a take one tablet by r cholesterol -MAR not signed for 4mg, Cetirizine 10m Atorvastastine 20m During interview on reported: -Recieved medicati -Medications are gi	01/13/20 the staff #1 ion training.				
	Professional report -Staff should check -Confirmed MAR w	01/13/20 the Qualified ed: and sign MAR daily. as not signed 11/15/19. nonth of November 2019 is no				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a saf	303 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and orderly e kept free from offensive				
	failed to ensure the	et as evidenced by: ion and interview, the facility facility was maintained in a manner. The findings are:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-759	B. WING			01/16/2020	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	• •		
ESTIN)	FAMILY CARE HOM	E	LENDALE DRIV	/E			
201111	I	RALEIGI	H, NC 27604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
V 736	Continued From pa	ge 4	V 736				
	-Client #1 and #2's urine and soiled clo areas. -Boxes were stacke -Extra Mattress in t leaning against the -Floor dirty with tras During interview 1/7 reported she: -Was new to the ho -Cleaned everyday -Agreed clients' roo for them to wash cli -Didn't know why the the wall During interview 1/7	sh, leaves and sand. 13/20 at 1:30pm with staff #1 ome om did smell "it must be time					

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