Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	<del></del>	R-	_
		MHL092-859	B. WING			4/2020
NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY, S	STATE, ZIP CODE		
L DESTINY FAMILY CARE HOME 2			RLANE ROAI 27511	D		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	ΓS	V 000			
A complaint and follow up survey was completed on December 4, 2020. Deficiencies were cited.  The facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living For Adults with Developmental Disabilities.						
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.  (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.  (d) Each facility shall have basic first aid supplies accessible for use.					
	fire and disaster dri each shift. The find During interview on (she first pointed to wall) - she could not ke she looked in the	, the facility failed to complete lls at least quarterly and on ings are:  11/20/20 staff #1 reported: the fire evacuation on the ocate the drills				

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

(X6) DATE TITLE

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		MHL092-859	B. WING			4/2020
NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY, S	STATE, ZIP CODE			
DESTINY FAMILY CARE HOME 2 1238 FAIR CARY, NC			LANE ROAI	D		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
V 114	Continued From pa	ge 1	V 114			
	<ul><li>clients went ou</li><li>clients went in t</li></ul> During interview on	the bathroom for a tornado drill 11/20/20 client #1 reported: ut her window if it was a fire				
		11/20/20 client #3 reported: ent to the mailbox ot in the tub				
During interview on 11/20/20 client #5 reported: - they went outside for a fire drill - she went in the hallway and put her head down						
	reported: - drills are practic - the fire and disafacility	11/20/20 the Licensee ced at the facility aster log book was at the I it and staff could not locate it				
	Professional report - the Licensee w drills - she will sometin they are completed overlooked	as responsible for completing mes review the drills to ensure since it was mostly e reviewed the drills were in				
	This deficiency con and must be correct	stitutes a re-cited deficiency ted within 30 days.				

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		A. BOILDING.		D 0		
MHL092-859		B. WING		R-C <b>12/04/2020</b>		
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
DECTIN	/ EAMILY CARE HOM	1238 FAIR	LANE ROAL			
DESTIN	FAMILY CARE HOM	CARY, NO	27511			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
V 118	Continued From pa	ge 2	V 118			
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	Continued From page 2 27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.					

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This Rule is not met as evidenced by:

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	MHL092-859	B. WING			04/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DESTINY FAMILY CARE HOME	2 1238 FAII CARY, NO	RLANE ROAD C 27511	)			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
failed to ensure MAR 3 audited clients (#2) Review on 12/2/20 or 10/20/20 revealed: - diagnoses of Sch Hypertension; Seizur - Lasix 20mg ever retention); (Cogentin QHS (can treat symp Aspirin 81mg QD (can attack); Colace 100m Synthroid 25mg morn hypothyroidism); Lipin cholesterol); Haldol 1 disorders); Desyrel 1 depression)  Review on 12/2/20 or revealed: - each medication between 10/8/20 - 10 - the rest of the Mark Mark was left blank - staff are not required spaces when the client puring interview on 1 reported: - nobody has required spaces when the client puring interview on 1 refersional reported: - she and License	iew and interview the facility Rs were kept current for 1 of ). The findings are:  If client #2's FL2 dated hizoaffective Disorder; res; Hypothyroidism ryday (can treat fluid 5 5mg Bid); Depakote 750mg otoms of Parkinson Disease); an reduce risk of hearting QHS (stool softner); ning (can treat itor 40mg QD (can treat mental 100mg QD (can treat	V 118				

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MH	L092-859	B. WING		12/04/2020		
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(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE F TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTE		
V 118 Continued From page 4  MARs - codes were on the back - there should be a code f - she would ensure staff f spaces when not at the facili  This deficiency constitutes a and must be corrected within	or the hospital illed in the blank ty re-cited deficiency	V 118				

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