STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-908	B. WING		R 08/09/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DESTINY	FAMILY CARE HOMI	= 3	BROOK ROA , NC 27610	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000 INITIAL COMMENTS		V 000				
	An annual and follo on 8/09/21. Deficier	w up survey was completed ncies were cited.				
		sed for the following service 100C Supervised Living for Ilness.				
V 118 27G .0209 (C) Medication Requirements		V 118				
	only be administered order of a person and drugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength,  (C) instructions for a (D) date and time the (E) name or initials drug.  (5) Client requests a checks shall be recorded.	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of led to each client must be kept administered shall be ely after administration. The				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.12 . 2.1.1	0. 00201.0		A. BUILDING:			R	
		MHL092-908	B. WING			≺ )9/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DESTIN	Y FAMILY CARE HOM	F 3	BROOK RO , NC 27610	AD			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 118	Continued From pa	nge 1	V 118				
	Based on observat interview, the facilit was current affectir and #6). The findir  A. Review on 8/5/2 revealed:  - Admitted: 7 - Diagnoses Schizophrenia - Physician's following medicatio Abilify 30 n daily (Schizophreni Trileptal 60 (anticonvulsant) Lithium Ca (Bipolar)  Review on 8/5/21 c 2021 MARs revealed - June 2021 No initials footnoon in the second state of the second sec	1 of Client #1's record 7/15/20 : Anxiety, Bipolar Disorder and corders dated 2/10/21 for the ins: ing (milligram) one tablet (tab) a) io mg one tab at night rbonate ER 450 mg one daily of Client #1's June and July ed: MAR noted the following: for Trileptal as administered on dications were administered MAR noted no initials the were administered on 30th of Staff #1's personnel record					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-908	B. WING		R <b>08/09/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
DESTIN	FAMILY CARE HOMI	= 3 1108 SEA	BROOK ROA	AD		
DESTINA	TAMILI CARLITOM	RALEIGH	, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	8 Continued From page 2		V 118			
	- Medication Certificate dated 2/	Administration Training 1/16				
	21st-24th, 2021.  - When clien would initial the MA on the reverse of th  - Prior to this of the codes on the  B. Review on 8/5/2 revealed:	as on a home visit June ts went for a home visit, he R opposed to using the code e MAR for out of facility. interview, he was not aware reverse of the MAR  I of Client #6's record				
	- Physician's following medication Magnesium (supplement for blo Vitamin D3 deficiency) Depakote S (anticonvulsant) Zyprexa 10 (Schizophrenia and Zyprexa 20 Prilosec 20 - Physician's Proamatine HCL 2. day (Hypotension) - July 2021 M	"Generalized Weakness" orders dated 11/9/20 for the hs: 1 400 mg one tab daily od flow and bone health) 2000 one tab daily (vitamin D GOD ER 500 mg one tab daily mg one tab at night				
	Interview on 8/6/21  - He primarily except for a few day  - MAR was in administered to clie	Staff #1 reported: y worked at the group home ys a month nitialed after medication was				

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STATE FORM 6899 4N9L11 If continuation sheet 3 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	7. Bolebino.		₹
		MHL092-908	B. WING			9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY	FAMILY CARE HOM	F 3	BROOK ROA , NC 27610	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	medications - Prior to intended the blanks on the Marks - The blanks Interview on 8/9/21 reported: - She did no - Agency util Nurse for trainings - Blanks on the forgot to initial.	erview, he was not aware of MAR on the MAR was an error the Qualified Professional toversee the medications ized consultant Registered the MAR normally meant staff make the Licensee aware of	V 118			
V 133	G.S. §122C-80 CR CHECK REQUIRE APPLICANTS FOR (a) Definition As a "provider" applies to program and any p developmental disa services that is lice Chapter. (b) Requirement provider licensed u applicant to fill a po applicant to have a conditioned on con criminal history rec the applicant has b less than five years is conditioned on co criminal history rec national criminal his include a check of		V 133			

Division of Health Service Regulation

STATE FORM 6899 4N9L11 If continuation sheet 4 of 12

DIVISION	Division of Health Service Regulation						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL092-908	B. WING		R <b>08/09/2021</b>		
		MIHE092-906			08/0	9/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DECTIN	/ FAMILY OADE HOM	1108 SEA	BROOK ROA	AD			
DESTIN	Y FAMILY CARE HOM	RALEIGH	, NC 27610				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 133	Continued From pa	ge 4	V 133				
	five years or more, on consent to a Stacheck of the applicant criminal history recessories extion. Except as subsection, within fine conditional offershall submit a requivalent of the conditional offershall submit a requivalent of the conditional offershall submit a requivalent of the conduct at the check required by the conduct at th	then the offer is conditioned ate criminal history record ant. A provider shall not a brid check required by this otherwise provided in this ive business days of making of employment, a provider est to the Department of 114-19.10 to conduct a brid check required by this mit a request to a private State criminal history record his section. Notwithstanding a Department of Justice shall of national criminal history mployment positions not					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		R	
		MHL092-908	B. WING			9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY	FAMILY CARE HOM	F 3	BROOK RO , NC 27610	AD		
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	/ 133 Continued From page 5		V 133			
V 133	section within five to conditional offer of All criminal history in provider is confider except to the applic (c) of this section. It is subsection, the term business regularly comminal history records obtained from (c) Action If an apprecord check revea a relevant offense, of the following fact hire the applicant:  (1) The level and section (2) The date of the (3) The age of the proviction.  (4) The circumstant commission of the (5) The nexus between the person and the filled.  (6) The prison, jail, rehabilitation, and experson since the date (7) The subsequential relevant offense. The fact of convictions are levant offense. The fact of convictions the provider disqueronsideration of the provider may disclose the day consideration of the day consideration of the day consideration of the day consideration of	pusiness days of the employment by the provider. Information received by the nitial and may not be disclosed, cant as provided in subsection for purposes of this in "private entity" means a engaged in conducting ord checks utilizing public om a State agency. Opplicant's criminal history also one or more convictions of the provider shall consider all cors in determining whether to deriousness of the crime. Operson at the time of the crime, if known, ween the criminal conduct of job duties of the position to be				
		on, but may not provide a copy ory record check to the				

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DIVIDION	of Fleatiff Service IN	syulation	1				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					-	2	
		MALII 000 000	B. WING		R		
		MHL092-908	B. WING		08/0	9/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		1108 SEA	BROOK ROA	AD			
DESTINY	FAMILY CARE HOM	F 3	NC 27610				
240.15	CUMMAN DV CTA			DDOV/DEDIC DI ANI OF CODDECTI	ON .	0.5	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE	
				DEFICIENCY)			
V/ 422	Cantinuad Frame no	C	V 133				
V 133	•		V 133				
		y A provider and an officer					
	or employee of a pr	ovider that, in good faith,					
	complies with this s	ection shall be immune from					
	civil liability for:						
		e provider to employ an					
		sis of information provided in					
		record check of the individual.					
		an employee's history of					
		the employee's criminal					
		k is requested and received in					
	compliance with this	•					
		se As used in this section,					
		neans a county, state, or					
		tory of conviction or pending					
		ne, whether a misdemeanor or					
		pon an individual's fitness to					
		for the safety and well-being of					
		ental health, developmental					
		tance abuse services. These					
	•	criminal offenses set forth in					
		Articles of Chapter 14 of the					
		Article 5, Counterfeiting and					
		ubstitutes; Article 5A,					
		ubstitutes, Article 5A, itive and Legislative Officers;					
		Article 7A, Rape and Other					
		•					
		ele 8, Assaults; Article 10,					
		duction; Article 13, Malicious					
		y Use of Explosive or					
		or Material; Article 14, Burglary					
		eakings; Article 15, Arson and					
		icle 16, Larceny; Article 17,					
		, Embezzlement; Article 19,					
		d Cheats; Article 19A,					
		or Services by False or					
		Credit Device or Other Means;					
		al Transaction Card Crime					
		ıds; Article 21, Forgery; Article					
		st Public Morality and					
	Decency; Article 26	A, Adult Establishments;					

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	<del></del>	COMIT LETED	
		MHL092-908	B. WING		08/0	? 9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DECTINA	/ FAMILY CARE HOM	1108 SEA	BROOK ROA	AD		
DESTINI	FAMILY CARE HOM	E 3 RALEIGH	NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE
7 100	Continued From page 7  Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public		V 133			
	Office; Article 35, C Peace; Article 36A,	Offenses Against the Public Riots and Civil Disorders;				
	Protection of the Fa	on of Minors; Article 40, amily; Article 59, Public				
	Crime. These crime	ticle 60, Computer-Related es also include possession or				
	sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter					
	90 of the General S	Statutes, and alcohol-related ale to underage persons in				
	violation of G.S. 18	B-302 or driving while				
	impaired in violation G.S. 20-138.5.	n of G.S. 20-138.1 through				
		ishing False Information Any yment who willfully furnishes,				
	supplies, or otherw	ise gives false information on				
		olication that is the basis for a ord check under this section				
		Class A1 misdemeanor. ployment A provider may				
	employ an applicar	nt conditionally prior to				
		s of a criminal history record e applicant if both of the				
	following requirement (1) The provider sh	ents are met: all not employ an applicant				
		ne applicant's consent for ord check as required in				
	subsection (b) of th	is section or the completed				
	(2) The provider sh	required in G.S. 114-19.10. all submit the request for a				
	business days after	ord check not later than five r the individual begins				
	2001-155, s. 1; 200	ment. (2000-154, s. 4; )4-124, ss. 10.19D(c), (h);				
	2000 <del>-4</del> , 55. 1, 2, 3,	4, 5(a); 2007-444, s. 3.)				

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Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		MHL092-908	B. WING		R 08/09/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DESTIN	Y FAMILY CARE HOM	F 3	BROOK RO , NC 27610	AD		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 133	Continued From page 8		V 133			
V 736	Based on record regoverning body fail national criminal his days of a condition staff (#2). The findi Review on 8/5/21 or revealed:  - Hired: 7/27 - County Cri 7/29/21 - No evidence Record check  During interview on Professional report - She was not check was obtained office only - Another co Record check for S 27G .0303(c) Facilit 10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf	of Staff #2's personnel records 7/21 minal Record check completed the of statewide Criminal a 8/6/21, the Qualified the direct: to aware the Criminal Record d at the local government tompany completed the Criminal staff #2 tity and Grounds Maintenance 303 LOCATION AND	V 736			

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AND PLAN OF CORRECTION  (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-908	B. WING		R <b>08/09/2021</b>	
	PROVIDER OR SUPPLIER	= 3 1108 SEA	DDRESS, CITY, SABROOK ROAL, NC 27610	STATE, ZIP CODE AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 736	failed to ensure the		V 736			
	be kept free from or are:  Observation and to	ffensive odor. The findings  ur of the facility on 8/5/21 nd 5:15 PM revealed the				
	following:  - Bedroom occupied by Client #5: Broken ceiling fan, fan blade laying on the floor Ceiling fan blades covered in thick dust					
	Strong smell of urine and body odor No toilet paper in the bathroom located inside his room Hinge on bedroom door was broken  - Bedroom occupied by Client #2:					
	- Bedroom o	h broken dresser drawer ccupied by Client #1: cco flakes scattered on the				
	Strong sme Bathroom f	nissing toilet lid				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		MHL092-908	B. WING		08/0	R 9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY	FAMILY CARE HOMI	F 3	BROOK ROA , NC 27610	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 736	- Living room Paint bubble Aluminum of With missing leg  - Kitchen: Paint bubble No covering - Hallway: Hole (approte the wall near the law Interview on 8/6//21 reported: - She was ave the hallway near the - She had note the living room, or to 27G .0304(d)(7) Min  10A NCAC 27G .03 EQUIPMENT (d) Indoor space reprior to October 1, square footage requirements of the living room of the living r	ed and peeled on the ceiling can used to prop up the couch ded and peeled on the ceiling g for overhead light fixture oximate size of a tennis ball) in undry room  , the Qualified Professional ware of the hole in the wall in the laundry room ot observed the bubbled and ceilings, bubbling of paint in the broken dresser or fan	V 736			
	each client.					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL092-908	B. WING		R 08/09/2021	
NAME OF			<u>I</u>		1 00/0	3/2021
NAME OF	PROVIDER OR SUPPLIER		BROOK RO	STATE, ZIP CODE AD		
DESTINA EVMILA CYDE HUME 3			, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 774	Continued From pa	ge 11	V 774			
	This Rule is not me Based on observating failed to provide storaffecting 2 of 6 client The findings are:  Observation on 8/5, 5:15 PM of Client's  Client #3 di Client #3: sin closet, there were and rest of clothes:  Client #4 di Client #4's hangers and piled of the personal items He had been been been been been been been bee	et as evidenced by: on and interview, the facility orage for personal belongings ints (Client #3 and Client #4).  //21 between 4:15 PM and #3-#4 bedrooms revealed: id not have a dresser come clothes were on hangers is no empty hangers in closet were in trash bags id not have a dresser clothes were hanging on on the floor of closet  with Client #3 reported: have enough storage for his en at the facility for a month with Client #4 reported: have a dresser and hung his ted additional furniture he would				

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