Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(22) MULTIPLE CONSTRUCTION A BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL032-389	B. WING	_			R 15/2022
PROVIDER OR SUPPLIER	STREET AD	DRESS, C	TY.	STATE, ZIP CODE		
	630 RIPPI	LING ST	RE	MI ROAD		
DESTINY HOME, INC DURHAM, NC 27704						
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EA		(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
INITIAL COMMENTS		V 000				
		÷			e.	
This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					ay 25, 2	2022
census of 6. The su	rvey sample consisted of			2.		
27G .0202 (A-E) Pe	rsonnel Requirements	V 107		. s		
REQUIREMENTS (a) All facilities shal description for the dwhich: (1) specifies the competency, work equalifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained in (b) All facilities shall each staff member of provides care or sent the facility: (1) is at least 18 (2) is able to refollow directions; (3) meets the macompetency, work exqualifications for the (4) has no substanglect listed on the Personnel Registry.	I have a written job irector and each staff position e minimum level of education, experience and other position; e duties and responsibilities of the staff member and the nature that the director, or any other person who vices to clients on behalf of a years of age; ad, write, understand and dinimum level of education, experience, skills and other position; and tantiated findings of abuse or			the survey. A review of all staff was conducted on 4/15/22. Going forward the administrato QP will conduct quarterly review personnel files to ensure all recommendations.	files or and ws of ords	
	PROVIDER OR SUPPLIER Y HOME, INC SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE INITIAL COMMENT An annual and follor on 4/5/22. Deficience This facility is licens category: 10A NCAC Living for Adults with This facility is licens census of 6. The sure audits of 3 current of 27G .0202 (A-E) Per 10A NCAC 27G .02 REQUIREMENTS (a) All facilities shall description for the description for the description for the descriptions for the competency, work equalifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained in (b) All facilities shall each staff member of provides care or sent the facility: (1) is at least 18 (2) is able to reafollow directions; (3) meets the moment of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the (4) has no substituted in the position of the position o	PROVIDER OR SUPPLIER STREET AD Y HOME, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 4/5/22. 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(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.	PROVIDER OR SUPPLIER STREET ADDRESS, C G30 RIPPLING ST DURHAM, NC 277 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 4/5/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. 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The survey sample consisted of audits of 3 current clients. 27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL. RECUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the duties and responsibilities of the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member and the supervisor; and (4) is retained in the staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) mests the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOB REPPLIENG STREAM ROAD DURHAMI, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATION OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 4/6/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current citents. 27G. 0/202 (A-E) Personnel Requirements 10A NCAC 27G. 0/202 PERSONNEL. REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member and the supervisor; and (4) is retained in the staff member and the position; (2) is able to read, write, understand and follow directions; (3) incets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Precounter ACTION ENDING ENDIN

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

TITLE

(26) DATE

STATE FORM



PRINTED: 04/08/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL032-389 B. WING 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 630 RIPPLING STREAM ROAD **DESTINY HOME, INC** DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 107 Continued From page 1 V 107 (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a complete personnel record affecting two of three audited staff (#1 and #2). The findings are: a. Review on 4/5/22 of the facility's personnel records revealed: -Staff #1 had a hire date of 7/31/21. -Staff #1 was hired as a Habilitation Technician. -There was no documentation of a job description

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for staff #1.

records revealed:

b. Review on 4/5/22 of the facility's personnel

-Staff #2 had a hire date of 3/21/22.

Divi	sion of Health Service R	egulation				APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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NAME	OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CIT	TY, STATE, ZIP CODE	1 04/	04/05/2022	
DES	TINY HOME, INC			REAM ROAD			
OVA	Olympia Transport	DURHA	M, NC 277	04			
(X4) PREI TAC	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	B D DC	(X5) COMPLETE DATE	
V 1	07 Continued From page	ge 2	V 107			-	
	-Staff #2 was hired a -There was no docu for staff #2.	as a Habilitation Technician. mentation of a job description					
V 11.	Interview on 4/5/22 or Professional revealer. The job descriptions staffShe had copies, but because she assume foldersShe confirmed there job descriptions for some interview on 4/5/22 or There was no docum for staff #1 and staff in this deficiency has be original cite on 3/2/17 within 30 days. 2 27G .0205 (C-D) Assessment/Treatment 10A NCAC 27G .0205 TREATMENT/HABILIT PLAN (c) The plan shall be considered assessment, and in pallegally responsible per of admission for clients receive services beyon (d) The plan shall included.	d: s were completed for both did not bring them with her ed the original were in their was no documentation of taff #1 and staff #2. ith the Licensee confirmed: nentation of job descriptions #2. een cited 5 time(s) since the and must be corrected ASSESSMENT AND FATION OR SERVICE developed based on the rtnership with the client or son or both, within 30 days who are expected to d 30 days. de: nat are anticipated to be	V 112	V 112 Assessment Treatment/Habi The QP met with the client immedi following the survey to obtain his signature of agreement to his treat goals. Going forward the QP meet to obtain signatures during the treatm update meetings.	ately tment will	an	
ion of He	projected date of achie (2) strategies; (3) staff responsible;						

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ R B. WING MHL032-389 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **630 RIPPLING STREAM ROAD DESTINY HOME, INC** DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 112 Continued From page 3 V 112 (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement: and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility the facility failed to have written consent or agreement by the client or responsible party affecting one of three clients (#1). The findings Review on 4/4/22 of client #1's record revealed: -Admission date of 5/11/10. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Hepatitis B & C, Avascular Necrosis of in both hips and Subclinical Hyperthyroidism. -Person Centered Plan (PCP) dated 6/20/21. -The PCP had no written consent or agreement by the client or responsible party. Interview on 4/5/22 with the Licensee revealed: -She didn't realize the PCP wasn't signed for

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client #1.

 She confirmed the facility failed to have written consent or agreement by the client or responsible

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING MHL032-389 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **630 RIPPLING STREAM ROAD DESTINY HOME, INC DURHAM, NC 27704** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 112 Continued From page 4 V 112 party for client #1. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. V 118 27G .0209 (C) Medication Requirements V 118 V 118 Medication Requirements The administrator filed all trainings and 10A NCAC 27G .0209 MEDICATION certifications in the personnel files REQUIREMENTS (c) Medication administration: immediately following the survey. (1) Prescription or non-prescription drugs shall The review of personnel files was only be administered to a client on the written conducted on 4/15/22 and all training order of a person authorized by law to prescribe documents, job description and other drugs. employment information was (2) Medications shall be self-administered by determined to be present. Both of the clients only when authorized in writing by the client's physician. staff were trained on medication (3) Medications, including injections, shall be administration prior to working alone administered only by licensed persons, or by in the facility. QP will conduct quarterly unlicensed persons trained by a registered nurse, reviews of personnel files to ensure pharmacist or other legally qualified person and all records are kept current and privileged to prepare and administer medications. contain all required documents. (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.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL032-389 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **630 RIPPLING STREAM ROAD DESTINY HOME, INC** DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 118 Continued From page 5 V 118 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications was administered by an unlicensed person trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications affecting two of three audited staff (#1 and #2). The findings are: Review on 4/5/22 of the facility's personnel records revealed: -Staff #1 had a hire date of 7/31/21. -Staff #1 was hired as a Habilitation Technician. -There was no documentation of medication administration training for staff #1. Review on 4/5/22 of the facility's personnel records revealed: -Staff #2 had a hire date of 3/21/22. -Staff #2 was hired as a Habilitation Technician. -There was no documentation of medication administration training for staff #2. a. Review on 4/4/22 of client #1's record revealed: -Admission date of 5/11/10. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Hepatitis B & C, Avascular Necrosis of in both hips and Subclinical Hyperthyroidism. Review on 4/4/22 of Medication Administration Record's (MAR's) for client #1 revealed:

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-April 2022 MAR-Staff #1's initials were listed.
-March 2022 MAR-Staff #1's initials were listed.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL032-389	B. WING			R 0 5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE		
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(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 APPROFIME DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	-February 2022 MAI listed. b. Review on 4/4/22 revealed: -Admission date of 3-Diagnoses of Schiz Cannabis Abuse and Review on 4/4/22 of April 2022 MAR-Sta-March 2022 MAR-Sta-March 2022 MAR-Sta-Diagnoses of Schiz Subacute Dyskinesia Review on 4/4/22 of April 2022 MAR-Sta-March 2022 MAR-Sta-Both staff had the matraining when they we-She was not sure wistaff foldersShe confirmed there	R-Staff #1's initials were of client #2's record 8/1/17. cophrenia, Cocaine Abuse, d Personality Disorder. MAR's for client #2 revealed: aff #1's initials were listed. Staff #1's initials were listed. R-Staff #1's initials were of client #3's record revealed: 8/20/20. ophrenia and Drug Induced a. MAR's for client #3 revealed: aff #1's initials were listed. claff #1's initials were listed. R-Staff #1's initials were with the Qualified d: nedication administration	V 118	DEFICIENCY)		
	Interview on 4/5/22 w -There was no docum	vith the Licensee confirmed: nentation of medication g in the personnel folder for				

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R B. WING MHL032-389 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 630 RIPPLING STREAM ROAD **DESTINY HOME, INC** DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 736 Continued From page 8 V 736 -Bathroom in hallway-One of the light fixtures had a burned out light bulb. Walls were stained and had peeling paint. The door frame had peeling -Hallway-The walls were stained and paint was faded. -Client #5's bedroom-Door was stained and had peeling paint. The door frame had peeling paint. -Client's #1 and #3's bedroom-The door was stained. The walls were stained and had peeling paint. -Bathroom in client's #1 and #3's bedroom-There was a strong urine odor. The shower curtain was stained. The blinds to the window were broken. -Client #4's bedroom-The blinds were broken. The door frame was stained and had peeling -Front door to the home had peeling paint. -Client's #2 and #6's bedroom-Both sets of blinds were broken. There was a musty odor. Outside window pane had a crack approximately 30 inches long. -Front yard-There were approximately 20 pieces of paper/trash on the ground. Interview on 4/5/22 with staff #1 confirmed: -The facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. Interview on 4/5/22 with the Licensee revealed:

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offensive odor.

-She was aware of most of the maintenance

grounds were maintained in a safe, clean, attractive, orderly manner and kept free from

-She had most of the repairs completed after the

-She confirmed the facility failed to ensure facility

issues with the group home.

survey last year in May 2021.

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ R MHL032-389 B. WING_ 04/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **630 RIPPLING STREAM ROAD DESTINY HOME, INC** DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 736 Continued From page 9 V 736 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

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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			
		MHL032-389	B. WING		04/0	5/2022		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE				
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DESTINY	HOME, INC	DURHAM,	NC 27704					
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V 118	Continued From page 7		V 118	*				
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.							
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.		V 736	V 736 Location & Exterior Requirements The facility has contracted with a painter. The contractor will begin painting all areas in need of painting on 4/30/22. The staff and clients living in this home are to ensure that the home is cleaned on a regular basis. Those clients needing assistance will get assistance from staff. Cleaning of bathrooms will be done on no less than a daily basis and should				
	failed to ensure facin a safe, clean, attributed in a safe, clean, attributed free from offer. Observation on 4/5 revealed: -Kitchen area-The vitable was scratched other walls were stated and faded. The doos stained and had per-Backyard area-The blocks on the groun mattress laying against pillow hanging out of-Living Room Area-	on and interviews, the facility fility grounds were maintained ractive, orderly manner and asive odor. The findings are: //22 at approximately 10:25 am wall behind the dining room dand had peeling paint. The ained and had peeling paint. Ow over the sink was stained or leading to staff's office was eling paint. ere was a door and 10 cinder of the chimney. There was a of the chimney. Door leading to hallway was eling paint. The walls were		be cleaned after each by the indivusing the bathroom. The QP met staff, administrator and client on maintaining this facility in a clean attractive and orderly manner. The QP will confer with the administrator and staff via phone or virtually on a weekly basis to ensure compliance. During month visits the QP will continue to do inspections and report to the administrator those things that must be done.	with , safe,			