| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|---|---|---|--|
| ******** | | MHL092-859 | B. WING | W | R 05/23/2022 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STA | TE ZIP COOF | , | | |
| | | | IRLANE ROAD | a send months. And also strains | | | |
| DESTINY | FAMILY CARE HOME 2 | | NC 27511 | | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | i ot | PROVIDER'S PLAN OF COP | | ()(5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | | DATE | |
| V 000 | INITIAL COMMENTS | , | V 000 | | *************************************** | | |
| 1 | An Annual and Calley | Up Survey was completed | | | | | |
| | on May 23, 2022, Def | | To the second se | | | | |
| | The facility is licensed | for the following service | | | | | |
| Ī | | 27G .5600C Supervised | | | | | |
| ŀ | | Developmental Disabilities. | | V 112- Client # 4's PCP v | Mac | | |
| | This do this to a | | | updated on 1/17/22 and | | Phone in | |
| | | i for 6 and currently has a | - | client # 5's PCP was upd | | 17 | |
| 1 | audits of 3 current clie | ey sample consisted of | | 3/3/22. As of 6/3/22, th | | | |
| | CAMILO OF J CUSTOSK GIRE | n (co. | | were again reviewed wi | e rups | * | |
| V 110 | 27G .0205 (C-D) | | V 112 | clients. All goals and stra | | | |
| * | Assessment/Treatmer | nt/Hahilitation Plag | VIIZ | | | | |
| 1 | , mooneymone monather | A ICOMODUCE COM | - | were reviewed as well. | | \$ 4 | |
| | 10A NCAC 27G .0205 | ASSESSMENT AND | | reviews included strateg | | | |
| 1 | TREATMENT/HABILIT | TATION OR SERVICE | | address client's diabetes | | 4 | |
| , | PLAN | | | diagnosis, which include | S | | |
| | | developed based on the | | signs and symptoms of | | *************************************** | |
| | | artnership with the client or | | diabetes, practice of hea | | ************************************** | |
| | | rson or both, within 30 days s who are expected to | 1 | eating and understandin | | *** | |
| | receive services beyor | | 1 | diabetes. Going forward | | İ | |
| | (d) The plan shall incli | | | records will be reviewed | | l i | |
| | | that are anticipated to be | | monthly by the administ | | | |
| | achieved by provision | of the service and a | | or designee. This review | | | |
| 1 | projected date of achie | evement; | | should be a cursory revie | w to | | |
| | (2) strategies; | | | ensure that all required | | | |
| | (3) staff responsible;(4) a schodule for row | iew of the plan at least | | documents are present. | | | |
| | | n with the client or legally | | Additionally, the staff wil | ł | | |
| | responsible person or I | | | ensure that all information | n is | | |
| | (5) basis for evaluation | | | replaced in the records at | | | |
| - 10 | outcome achievement; | and | | appointments, | | | |
| | | agreement by the client or | } | hospitalizations, crisis | | | |
| | | written statement by the | | contacts, etc | | | |
| | provider stating wny su obtained. | ich consent could not be | | | ······································ | | |
| uses equidique | | | 4 | | | | |
| n of Health | h Service Regulation | (44) | <u> </u> | | | <u> L</u> , | |
| ATORY DIE | RECTOR'S OR PROVIDER/BU | PPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | (| (X8) DATE | |
| XQ. | w Katt | BA. Q | <u> </u> | | 7127 | 122 | |
| FÖRM | | | 19656 | Vent | | intlan short | |

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MJVC11

By DHSR Mental Health Licensure & Certification at 4:45 pm, Aug 02, 2022

Division of Health Service Regulation

| Division o | f Health Service Regu | lation | | | | *************************************** |
|-------------------|---------------------------------------|--|---|---|-------------|---|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPL. | ETED |
| | | | | | . | |
| | | \$411 DO2 550 | B. WING | | ne# | |
| | | MHL092-859 | | | U3/2 | 23/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AC | DRESS, CITY, STAT | re, zip code | | |
| | | 1238 FAIF | RLANE ROAD | | | |
| DESTINY | FAMILY CARE HOME 2 | CARY, NO | | | | |
| do | M7 24 M 4 A M 27 M 7 | , , , , , , , , , , , , , , , , , , , | 3 | montenentid milesi Af AAAAMAMA | | n.idi. |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | DEFICIENCY) | | da Booone |
| V 112 | Continued From page | . 7 | V 112 | | | |
| V 112 | Continued Light bage | 5 (| V 112 | | | - |
| | | | | | | |
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| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| ļ | | | | | | |
| ĺ | This Rule is not met | as evidenced by: | | | | } : |
| | | ew and interview the facility | | | | |
| | | nent plans were reviewed | | | | |
| | | iltation with three of three | | | | |
| | • | 4 and #5). In addition, the | | | | |
| | | op and implement strategies | 1 | | | |
| ļ | | eet the needs for one of | Ì | | | |
| | | #5). The findings are: | | | | |
| | inco addica cilcina (| man creation and and a | | | | |
| İ | I. Review on 5/18/22 | of client #2's record | | | | |
| ļ | revealed: | or didne ned rooms | ! | | | |
| | - Admitted: 10/10/ | מיו | | | | |
| | | itis, Hypertension, Mental | | | | |
| | | y Arteries Disease and | | | | |
| İ | Hyperlipidemia | y Arteries Disease and | | | | |
| į | * * * | ated 4/4/21 listed goals | | | | |
| ļ | related to the following | | | | | |
| | , | health by cooperating with | | | | |
| | • | to promote early detection, | *************************************** | | | |
| | | tills and eliminate behaviors | **** | | | |
| 1 | | | | | | |
| | meds taken consisten | octioning is positive and | | | İ | ļ |
| | | • | - | | | |
| i | respect for social norr | constrate healthy sense of | | | | |
| ļ | | | **** | | | |
| [| | program activities | Accelera | | | ·] |
| | 2022 | n updated or reviewed for | | | | |
| 1 | | ur accom an candian | | | | |
| ļ | - She served as he | a own guardian. | *** | | 1 | • |
| [| | Ranal HM alabada | N. AMARIAN | | | |
| | Interview on 5/19/22 of | | | | | |
| | | re of a treatment team | and the second | | | |
| | meeting or discussion | | | | 1 | . |
| | The Qualified Pro | ofessional (QP) may be able | a. | | | |

Division of Health Service Regulation

STATE FORM

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MJVC11

If continuation sheet 2 of 34

| AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (A. BUILDING: | | | E SURVEY PLETED |
|--|--|--|--|--|---|--------------------|
| | MHL092-859 | | B. WING | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE | 5 710 AAAR | | 5/23/ <u>2</u> 02; |
| Bitorius | = 4 b b r 1 b 0 m 1 | | IRLANE ROAD | =, ZIF CODE | | |
| DESTINY | FAMILY CARE HOME 2 | | NC 27511 | | | |
| (X4) ID PREFIX | SUMMARY ST | FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL | l aı | PROVIDER'S PLAN C | OF CORRECTION | (× |
| TAG | REGULATORY OR | LSC (DENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | THE APPROPRIATE | COM |
| V 112 | Continued From page | a 2 | V 112 | | | |
| | to further provide mor | re information | | | | |
| A mer con | II. Review on 5/18/22 revealed: | | | | | |
| Contraction of the contraction o | - Admitted: 4/10/12 - Diagnoses: Hype | 2 rlipidemia, Anxiety and | | | | |
| Aus : Absolutions of | Allergy Treatment plan d related to the following | ated 4/2/21 listed goals | | | | |
| Months | learn to manage i triggers by implement | symptoms and identify ing coping skills in the | | | | |
| - | home/community improve daily livin following through with | ig/productivity skills by | T acceptance | | | |
| i | improve her quall | by of life by increasing her bloyment skills in order to | Principal | | | |
| j | obtain employment | program activities | | | | |
| | No treatment plan | updated or reviewed for | | | | <u> </u> |
| } - | She served as her | own guardian | | | | |
| | nterview on 5/18/22 ci | ient #4 stated; | William Washing | | | |
| 1 | it had been "a few her goals, | years" since she reviewed | deline a page deline | | | |
| | ll. Review on 5/18/22 o svealed: | of client #5's record | | | | |
| - - | Admitted: 1/11/21 Diagnoses: Sacroc | occygeal Disorder, Type 2 | | | | |
| | //apetes, GERD (Gastr | roesophageal Reflux tis, Hyperlipidemia, Down | | | <u>}</u> | |
| s | yndrome and Nausea | | | | 1 | |
| re | liated to the following: | ed 2/4/21 listed goals | Water and the control of the control | | | |
| PI | romote early detection | | | | en and and and and and and and and and an | |
| | Increase independe | ent living skills via activitles | # Head | | • Permittors som | |
| (C l pi | hores, bathing, wearin ecautions) increase pr Service Regulation | g masks, Covid oductivity and safety | STATE OF THE PARTY | | . пинумуни | |

| UIVISION (| of Health Service Regu | lation | | | | |
|---|--------------------------|--|--------------------|---------------------------------|----------------|-----------------|
| STATEMEN" | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURV | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A, BUILDING: | | COMPLETED | • |
| | | | | | R | |
| | | SHUL AAR DES | 8, WING | | 05/23/20 | 177 |
| | | MHL092-859 | | | V 37 2 31 41 4 | 7 Au Fo |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DORESS, CITY, STAT | TE, ZIP CODE | | |
| | | 1238 FAII | RLANE ROAD | | | |
| DESTINY FAMILY CARE HOME 2 CARY, NC 27511 | | | | | | ; |
| | | , | f | PROVIDER'S PLAN OF CORRECTION | | CVEX. |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | | (X5) OMPLETE |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | DEFICIENCY) | | |
| 1/ 449 | Continued From page | . 2 | V 112 | 100 | ļ | |
| V 112 | i Couttinen Liou bade | 3 3 | 1 | | l | |
| | awareness by refusin | g to engage in activities or | | | | |
| | wandering improve de | ecision making abilitles with | 1 | | • | |
| | no more than one pro | ompt | - American | | | |
| | behaviors of des | troying clothing, cutting hair, | | | ļ | |
| | elopement, stealing to | o obtain attention. | | | } | |
| | | er own guardian. | , | | | |
| | | • | | | } | |
| | A. Interview on 5/18/2 | 22 client #5 stated: | | | į | |
| | - "No treatment me | eeting in a while. It's been a | | | • | |
| | year so." | • | | | į | |
| | | | 1 | | | · |
| | Interview on 5/19/22 | the QP stated: | | | | |
| | - Early this year, s | he had met with the clients | | | <u>}</u> | |
| | and established goals | | | | | |
| | _ | e why the clients did not | | | - | |
| | recall the treatment p | - | | | į | |
| | | plain what happened to the | | | | |
| | treatment plans comp | | | | } | |
| | | rd the current treatment | 1 | | ; i | |
| | | ealth Service Regulation | | | i | |
| | (DHSR). | | | | - | |
| | , | | | | | |
| | B. Review on 5/18/22 | of client #5's record | | | | |
| | revealed: | | 1 | | | |
| | - Physician's note | dated 5/10/22: | | | } | |
| | | ay above her normal 10.3 | | | | |
| | from 11/5/21 visit. | • | | | 1 | ; |
| | i | as been running around 220 | Lamporate | | į | |
| | in the AM fasting. | | *** | | | i |
| | . • | late on her follow up | | | | |
| | | n for regular visits as | | | , | |
| | directed. | | | | | |
| | Glucose has incr | eased significantly and if she | | | | |
| | | s earlier as directed this | | | ; ; | |
| | could have likely beer | | | | • | |
| | fingerstick checked in | | · | | *** | |
| | | G results in 2 weeks. | | | - | |
| | | had been assessed | | | | |
| | | o check and document her | | | * | |
| | Blood Glucose (BG) r | | All southern | | • | |

Division of Health Service Regulation

STATE FORM MJVC11 If continuation sheet 4 of 34

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: _ MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 GARY. NG 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 112 Continued From page 4 V 112 Interview on 5/18/22 client #5 stated: She used to live at home with her father prior to being admitted to the group home. While living at home with her father, her physician taught her how to check her BG levels. Her BG levels ran 120, 140 up to 180. She would only tell group home staff the readings "if it was high like 300." The day (5/10/22) she went to the doctor, her BG was high because she had "snacked" prior to the appointment. The doctor increased her insulin from 34 units to 44 units because of the BG and the A1C being high. She was supposed to keep track of her BG numbers and follow up with the doctor in a few she "keep forgetting" to write down her BG numbers. "Now, I got to figure out the numbers." Later. she said she would just tell the doctor she forgot to write down the numbers. Review on 5/20/22 of an email correspondence dated 5/20/22 from the QP revealed: She would not be able to send the copies of the treatment plans prior to the 12 Noon requirement due to a scheduling conflict, multiple DHSR surveys at the same time and an unexpected emergency. V 114 27G ,0207 Emergency 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

Division of Health Service Regulation

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MJVC11

if continuation sheet 5 of 34

| Division of Health Service Regulation | | | | | | |
|---------------------------------------|---------------------------------------|---|--------------------|--|-------------------------------|--|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPIJER/CLIA | 4 | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND PLAN | of Correction | IDENTIFICATION NUMBER: | A BUILDING: | | COMPETED | |
| | | | | | R | |
| | | 400 AND SER | B. WING | | 05/23/2022 | |
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| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, ST. | ATE, ZIP CODE | | |
| | | 129A EA | IRLANE ROAD | | | |
| DESTINY | FAMILY CARE HOME 2 | | | | | |
| | | CART, | NC 27511 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI | | |
| TAG | MEGODIORI ON | ESC DENTIFERED ASSOCIATION | i | DEFICIENCY | | |
| | | | | | | |
| V 114 | Continued From page | 9 5 | V 114 | | | |
| | | | 1 | 1 | | |
| | authority. | | 1 | | | |
| | | made available to all staff | 1 | | | |
| | | edures and routes shall be | | V 114 As of 6/3/22 staff & the | | |
| | posted in the facility. | | | Administrator were inserviced | | |
| | (c) Fire and disaster | drills in a 24-hour facility | | 1 | | |
| | shall be held at least | quarterly and shall be | | on procedures and protocols for | 1 | |
| | | ift. Onlis shall be conducted | 1 | conducting fire & disaster drills. | | |
| | | simulate fire emergencies. | į | The residential staff will comple | te | |
| | | have basic first aid supplies | 1 | the drills on no less than a mont | 1 1 | |
| | accessible for use. | | ! | 1 | | |
| | | | Ė | basis and will be completed on a | 111 | |
| | | | | shifts within the quarter. The | | |
| | | | | administrator will ensure drills | | |
| | | | | have been completed on a | | |
| | Thin Dala is not more | man and desired them | 1 | | | |
| | This Rule is not met | | | monthly basis and will | i | |
| | | ew and interview the facility | ĺ | co-sign the form once complete | d. | |
| | | and disaster drills at least | | The drills will be completed by | | |
| 4 | quarterly and on each | n shift. The findings are: | 1 | direct care staff and will be | 1 | |
| 1 | | | į | Company of the compan | 1 | |
| | Review on 5/18/22 of | the facility's drills sent via | 1 | monitored by the administrator | | |
| | email to Division of H | ealth Service Regulation | i . | during the review at the end of | 1 | |
| | (DHSR) by the Qualif | ied Professional (QP) | į. | each month. | | |
| 13 | revealed the following | documentation between | ľ | | | |
| 3 | January 2022-May 20 | | 1 | | | |
| ļ | - No disaster drifts | | | I | | |
| | | ompleted by the Licensee on | | | 1 | |
| | | 3/22 at 9:00 PM, 3/2/22 at | 1 | 1 | ì | |
| i | | 02 PM and 5/3/22 at 6:53 | 1 | | | |
| | PM. | AT I BURIE OLOUGE OF ALCO | | | | |
| | | ما لم المام | | | | |
| | | drills were completed by | 1 | | | |
| | House Manager/staff | #1 or Former House | | | | |
| | Manager/staff #2 | | | | | |
| | | . Fi | 1 | | | |
| ĺ | | he House Manager/staff #1 | 1 | | | |
| | stated: | | | | | |
| | Facility operated | | į | | | |
| 1 | - She had not beer | n off since she started | | | | |
| | working at the facility. | | | | | |
| | | at the facility 3 months. | 1 | | | |
| | | staff that worked at the | | | | |
| VISION OF HER | In Service Regulation | | | | | |
| TATE FORM | | | 1999 | 1.5/044 | II nauticular tout out as | |
| ~! JAN | | | | MJVC11 | If continuation sheet & of 34 | |

STATE FORM

| Division o | if Health Service Regu | lation | | | (X3) DATE SURVEY |
|----------------|--------------------------|---|--|--|--|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | COMPLETED |
| | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | Physical Marie a proper |
| | | | | | R |
| | | | | | 1 |
| | | MHL092-859 | B. WING | | 05/23/2022 |
| | | | | | 1 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | E, ZIP CODE | |
| | | 1238 FAI | RLANE ROAD | | 1 |
| DESTINY | FAMILY CARE HOME 2 | | | | |
| CARY, NC 27511 | | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | |
| PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | CROSS-REFERENCED TO THE APPROP | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | DAT | DEFICIENCY) | WIII WARRANG TO THE THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE TO THE |
| | | | | | |
| Vada | Carting and Community | ~ C | V 114 | | 1 |
| V 114 | Continued From pag | eo | , , , , , | | • |
| | facility. | | | | |
| | | - eff werk since the started | | | } |
| | 1 . | on off work since she started | | | <u>;</u> |
| | working at this facility | | | | |
| | | npleted fire or disaster drills | | | |
| | since her employmer | | | |) } |
| | - The Licensee ke | ept the fire and disaster drills | | | |
| | book with her. | • | | | |
| | | | 1 | | |
| | Interview on 5/18/22 | aliant #4 stated: | • | | |
| | | | | | |
| i | | or disaster drills." | | | ì |
| | | ire, I would meet at the | | | P |
| 1 | mailbox at the end o | f the driveway. I would go | | | |
| | somewhere with no | windows." | | | and the same of th |
| | - Someone had to | old her before what to do in | | | - |
| | | ster. She did not recall who | | | |
| | | Springers and the service programme the service of | | | * |
| 1 | told her. | in this trains appointed | | | |
| 1 | | w in this house specifically | | ı | * |
| | where to go in case | of disaster or fire drill. | | | 1 |
| | | | | | |
|] | Interview on 5/18/22 | client #5 stated: | | | |
| 1 | - "I don't rememb | er off hand when" the last | | | i E |
| | | oleted. Former House | | | |
| | | the home. It was in 2021 not | | | |
| | | the hollie. It was in 202 i not | | | |
| | 2022. | A. A. A. A. A. A. A. A. A. A. A. A. A. A | | | |
| 1 | | vould go outside and up the | | | |
| | hill "so house (fire) v | vould not burn me." | | | } |
| 1 | - She recalled pri | acticing a fire drill only once | | | |
| | | ission to the group home. | ì | | \$ * |
| | | actice tornado" drill. I would | | | |
| | | or in bathroom. But not sure | 1 | | |
| 1 | | | | | |
| | | is house, I don't know." | | | |
| | | ing a tornado drill, the clients | | | |
| 1 | got in the bathtub. | | | | |
| | | | 1 | | |
| | Interviews on 5/10/2 | 2 and 5/20/22 the QP stated: | | | |
| 1 | | ire and disaster drills were | 1 | | |
| | | | 4 | | |
| | | icensee. She would obtain the | - The state of the | | |
| 1 | | see and email them to DHSR. | 7 | | |
| | | axed DHSR the drill | and the same of th | | |
| 1 | | from the Licensee on | e-waren | | |
| | atte Camina Campintina | | | ······ | |

Division of Health Service Regulation

STATE FORM

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MJVC11

If continuation sheet 7 of 34

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 MHL092-859 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 CARY, NC 27511** (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 114 | Continued From page 7 V 114 5/19/22. The Licensee only provided the fire drill V118 An extensive training on information to be faxed to DHSR. diabetes care, management, documentation, signs/symptoms of Interview on 5/20/22 the Licensee stated: She conducted both fire and disaster drills. hyper and hypoglycemia was She was not sure why clients would indicate conducted by the pharmacy RN no drills were conducted. between 6/2 and 6/9. Additionally, Sometimes the clients were "nervous when the training focused on proper interviewed." medication storage. QP met with the staff and administrator to discuss This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. expectations for communication with direct care staff covering in the V 118 27G .0209 (C) Medication Requirements V 118 home upon client's return to the group home after appointments. 10A NCAC 27G .0209 MEDICATION The staff should not assume the REQUIREMENTS responsibility to make decisions (c) Medication administration: about how and when a client will be (1) Prescription or non-prescription drugs shall only be administered to a client on the written responsible for storing their own order of a person authorized by law to prescribe meds without a Dr's approval and proper medication storage (2) Medications shall be self-administered by containers being in place and the clients only when authorized in writing by the administrator and QP's awareness. client's physician. he administrator should ensure that (3) Medications, including injections, shall be administered only by licensed persons, or by all paperwork, Dr. orders and unlicensed persons trained by a registered nurse, outcomes of visit are reviewed with pharmacist or other legally qualified person and that staff on duty. If a client has an privileged to prepare and administer medications. order to self administer medication, (4) A Medication Administration Record (MAR) of conduct blood sugar checks and/or all drugs administered to each client must be kept administer insulin, by a licensed current. Medications administered shall be recorded immediately after administration. The professional, all these must be MAR is to include the following: completed in the presence of staff (A) client's name; during every check and each time (B) name, strength, and quantity of the drug; these independent practices are (C) instructions for administering the drug; (D) date and time the drug is administered; and completed. Division of Health Service Regulation

STATE FORM

MJVC11

Ricontinuation sheet 8 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING; A. WING MHL092-859 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** V 118 Continued From page 8 V 118 V118 Continued: Staff has been (E) name or initials of person administering the inserviced and advised that drug. (5) Client requests for medication changes or completion of MARs at the time checks shall be recorded and kept with the MAR medications are administered is file followed up by appointment or consultation mandatory and not optional. There with a physician. should be absolutely no delay of documenting when medications are given. Medications will be given only as ordered by a licensed prescriber and at no time will any medication be given to a client, including over the counter meds without a Dr's This Rule is not met as evidenced by: Based on observation, record review and order. The facility staff or interview the facility failed to ensure MARs were administrator should ensure that the kept current and assure medications were pharmacy is delivering medications administered as written for three of three audited on the specific cycle for that group clients (#2, #4 and #5). The facility failed to home. Staff should always call in assure medications were self administered by medications that are not on the clients only when authorized by the client's physician for one of three audited clients (#5). cycle at least 7 days in advance of The findings are: that particular medication running out. It is the responsibility of the I. Cross reference 10A NCAC 27G ,0209 person accompanying client to the MEDICATION REQUIREMENTS (V120), Based Dr's appt to obtain documentation. on observation, record review and interview the The medical provider does not facility failed to assure medications refrigerated with food items were kept separate in a locked always provide documentation compartment or container for one of three audited (contrary to what was stated by the clients (#5). practice). If a medication arrives and there is no order, then the staff is II. The following are medication issues regarding not to administer that medication client #5. unless the order is available and Review on 5/18/22 of client #5's record revealed: physically present in the group Admitted: 1/11/21 home. At no time is a medication Diagnoses: Sacrococcygeal Disorder, Type 2 given without an order being in the Diabetes, GERD (Gastroesophageal Reflux home. Disease), Allergic Rhinitis, Hyperlipidemia, Down Division of Health Service Regulation

STATE FORM

MJVC11

If continuation sheet 9 of 34

Division of Health Service Regulation

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: MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 Continued From page 9 V 118 Syndrome and Nausea FL-2 signed by physician dated 5/6/22 listed medications that included: Toujec Max 300 units/Milliliter (ml) inject 34 units subcutaneously at night (Diabetes) Glyxambi 10 milligram (mg)-5mg one tablet (tab) daily (Diabetes) Pantoprazole SOD DR (Sodium Delayed Release) 20mg one tab daily (GERD) Trazadone 50mg one tab at night (Insomnia) Venlafaxine HCL ER (Hydrochloride Extended-Release) 150mg one tab daily (Antidepressant and Nerve pain) Atorvastatin 80mg one tab at night (High Cholesterol) Lisinopril 2.5mg one tab daily (Hypertension) Cetirizine 10mg one tab daily (Allergies) Primary Care Physician's (PCP) visit note dated 5/10/22 listed the following changes: Glyxambl increased to 25mg one tab daily. Toujeo was increased to 44 units at bedtime. "Check BG (Blood Glucose) in AM fasting dally X (times) 2 weeks..." No physician's order to self administer insulin medication. A. No physician's order to self administer insulin. Review on 5/20/22 of client #5's PCP notes signed and maintained by her PCP revealed the following regarding her June 11, 2021-May 20, 2022 visits: She had been seen 4 times in which her Diabetes was addressed. The 6/11/21 note reflected client was seen to establish care. Her "A1C is 9.9 today... She is on levemir 34 units qd (daily) but states that she sometimes changes her dose from am to pm... Division of Health Service Regulation STATE FORM

MJVC11

If continuation sheet 10 of 34

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: B. WING MHL092-859 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2** CARY, NC 27511 SUMMARY STATEMENT OF DEFICIENCIES (X41 ID PROVIDER'S PLAN OF CORRECTION Ю (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 118 Continued From page 10 V 118 ...pt (patient) instructed to Inject levemir more consistently instead of alternating between pm and am dosing... She is also on Jardiance 10mg qd..." The PCP "may inc (increase) jardlance to 25mg depending on how her renal functionings looks," Her BG was checked in the PCP's office with a 362 reading. "Her glucose was high due to non-compliance with her levemir..." The 6/29/21 note reflected sho was seen to address pain due to a fall and a follow up of 6/11/21 visit. "Will check UA (urine analysis) today as she is on SGLT2 (sodium glucose transport protein 2 used to treat type 2 Diabetes) and is a diabetic... She used to not take her levemir every day as directed but now takes it every night." The 11/5/21 note reflected she was seen at a follow up visit from 6/29/21. "...A1C is 10.3 today which is slightly up..." and glucose had been running around 110 in the AM fasting. Her BG checked was conducted in the PCP's office with a 213 reading. Jardiance and Levemir were discontinued. Glyxambi and Toujeo were started. The 5/10/22 note reflected a physical exam was completed. Her "A1C is 11.6 today above her normal 10.3 from 11/5/21 visit ... Glucose has been running around 220 in the AM fasting.... Glucose has increased significantly." Her BG check was conducted in the PCP's office with a 232 reading.

Division of Health Service Regulation

STATE FORM

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MJVC11

If continuation sheet 11 of 34

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| | IENT OF DEFICIENCIES AN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | | SURVEY PLETED |
| | | MHL092-859 | B, WING | 40.944 | ٨٤ | R /23/2022 |
| NAME C | F PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STATE | E. ZIP CODE | <u>1</u> 0 | 12312022 |
| DESTI | NY FAMILY CARE HOME 2 | 1238 FA | IRLANE ROAD | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| (X4) [C PREFI TAG | X : (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 1 | 18 Continued From page | ə 11 | V 118 | 4.00 | | |
| alon of Mr | to being admitted to the While living at he physician taught her Fusher and the group home administer medications for the group home administer medication interview on 5/18/22 the stated; She started working ago Since her employed self administered her in She did not obsert her Insulin. Client #5 Informed self administered. B. Medications administered. B. Medications administered. Review on 5/18/22 of Mosages on the 17th arrevealed: No initials to reflect 5/6/22 FL-2 and 5/10/22 note were administered. Interview on 5/18/22 clies. She received all hed days (17th and 18th). | at home with her father prior the group home. The group home. The with her father, her how to administer insulin. The had self administered her of ever 4 years. The House Manager/staff #1 The grat the facility 3 months The House Manager/staff #1 The grat the facility 3 months The House Manager/staff #1 The grat the facility 3 months The House Manager/staff #1 The grat the insulin was The staff after the insulin was The staff after the insulin was The grat the grat from the grat the grat was The medications from the grat was The medications the past two The House Manager/staff #1 The grat PM dosages on The Grat House Manager/staff #1 The grat PM dosages on | | | | |

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If continuation sheet 12 of 34

| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (| CONSTRUCTION | [/X3) DAT | SURVEY | |
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| | · | AMILIA OVERNI HOMBEK: | A. BUILDING: | | | PLETEO | |
| | | MHL092-859 | B. WING | | ****** | R | |
| NAME OF P | ROVIDER OR SUPPLIER | Proser | ······································ | | 05 | /23/2022 | |
| | FAMILY CARE HOME 2 | | ADDRESS, CITY, STATI IRLANE ROAD | E, ZIP CODE | | | |
| ~~~ | TAIMILT CARE HOME 2 | | NC 27511 | | | | |
| (X4) ID PREFIX | SUMMARY S | STATEMENT OF DEFICIENCIES IGY MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF | COMPECTION | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE | TON SHOULD BE THE APPROPRIATE | COMPL COMPL DAT | |
| V 118 | Continued From pag | ge 12 | V 118 | | | | |
| | clients. | | ' ' ' | | | ! | |
| - Incompany | • • | ware" the MARs for clients | 1 | | |] | |
| | #2, #4 and #5 had n | ot been initialed immediately | } | | | j | |
| *************************************** | after the medication | was administered | | | | ļ | |
| AMERICAN COMM | She walted to in | itial the MARs 2-3 days at a | [| | | | |
|) | time. | | | | | 1 | |
| ************************************** | - She had been "t | ousy taking care of clients." | | | | | |
| | C. MAR not current f | Or nhysiolanie orda- | | | | | |
| 1 | regarding BG checks | or physician's order | 1 | | | İ | |
| | | | | | | i i | |
| | Review on 5/18/22 of | client #5's record revealed; | • | | | | |
| i | PCP visit notes of | lated on 11/5/21 & 5/10/22 | | | | İ | |
| | were signed by her pl | hysician. The notes reflected | | | | Į Į | |
| 1 | DO CHECKS ONLY BE IS | Sting in the AM dally. The | **** | | | | |
| | in 2 weeks." | Follow up with BG results | | | ļ : | | |
| - | - March-May 2022 | MARs listed pre-typed | | | ļ | | |
| , m | instructions for test sti | rips "Use as directed to | | | ļ | | |
| (| oneck blood sugar thr | ēs times dailv." | 1 | | | | |
| | April and May ref | lected staff initialed BG was | | | | | |
| (| checked at 8 PM only. | | 5 T | | • | | |
| | nterview on 5/18/22 c | llent #5 stated: | training turns | | | | |
| - | She checked her | BG levels twice a day | | | | | |
| , * | orice in the morning a | ind once at night." | | | · Prostings | | |
| <u> </u> | Changes had not | been made to her BG | T | | non - seco | | |
| i C | hecks. | | ******************************** | | | | |
| In | nterview on 5/18/22 th | e House Manager/staff #1 | Procedurate Annual Control of the Co | | Afternoon and an artist and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second an | | |
| st | latec: | | A Marian | | overland . | | |
| ļ <u></u> | She did not observ | e the BG checks | Parameter | | Vingolina projecti. | | |
| CC | anducted by client #5 | | *************************************** | | A 11000000 | | |
| - | She did not docum | ent the results of the BG | View . | | MARTINE REPORTED | | |
| re | adings | 1 | - | | . cooling | | |
| - | Client #5 would inc | licate she checked her BG. | ************************************** | | Moder of rap | | |
| In | terview on 5/19/22 the | 9 Qualified Professional | MININA MARINE MA | | | | |
| (C | P) stated: | | and the same of th | | † | | |
| - | She thought the fac | cility had obtained a | ************************************** | | 1 | | |
| of Health S | Service Regulation | The second secon | | | | | |

STATE FORM

MJVC11

If continuation shoet 13 of 34

| Division | <u>of Health Service Regu</u> | lation | | | FOR | M APPROVE |
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| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (A. BUILDING; | CONSTRUCTION | (X3) DATE COME | SURVEY PLETED |
| | | MHL092-859 | B. WING | | 1 | R |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ODRESS, CITY, STATE | C 7lg cooc | (05) | 23/2022 |
| DESTINY | FAMILY CARE HOME 2 | | RLANE ROAD | e, air quue | | |
| | | CARY, N | IC 27611 | | | |
| (X4) ID PREFIX TAG | (LACH DEFICIENC) | NEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE LE APPROPRIATE | (X6) COMPLETM DATE |
| V 118 | Continued From page | 13 | V 118 | | | İ |
| | physician's order for comedications. She last reviewed in January 2022. She could not recovered in January 2022. The January 2022 have occurred prior to employment at this local employment at this local employment. The House Managitrained in Medication Activation of the Insulin. For clients that self tooth the client and staff. | lient #5 to self administer medications at this location all if she saw the BG furing her January 2022 medication review would House Manager/staff #1's ation. louse Manager/staff #1 at this facility. er/staff #1 had been | V 118 | | | |
| ļ | everse of the MAR by s D. MAR not reflect wher dministered; | | All of Market and Mark | | | |
| th | r client #5's medication. Nystatin Topical Povinee times a day under Flovent HFA (Hydro: icrogram (mcg) inhale : isthma) Ondansetron ODT 4 ree times a day as nee | wder 100,000 units apply breast (Antifungal) fluoroalkane) 44 2 puffs twice a day mg dissolve one tab ded (prn) for nausea | | | | |
| rev - int Sh | eview on 5/18/22 of a Faintained by client #5's vealed: "She also states tha ermittent nausea over the has had this in the paservice Regulation | PCP dated 5/10/22 t she has had the past few months | | | | |

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MJVC11

If continuation sheet 14 of 34

| Division | n of Health Service Regu | <u>llation</u> | | | FOI | RM APPROVED |
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| STATEME | INT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
| <u></u> | | MHL092-859 | B. WING | - | 0. | R 5/23/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | |
| DESTIN | Y FAMILY CARE HOME 2 | | RLANE ROAD | 11 and 5 man are and mile | | |
| | | CARY, N | C 27511 | | | |
| (X4) ID PREFIX TAG | (EACH DEPICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO (EACH CORRECTIVE ACTIO (EACH) CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE ÉAPPROPRIATE | (X5) COMPLETS DATE |
| V 118 | Continued From page | 14 | V 118 | | | <u>:</u> |
| | goes. She is on protoi | nix for GERD and states controlled. She denies | | | | |
| | MARs revealed: - Pre-typed Floveni twice a day, Nystatin t apply three times a da Ondansetron ODT 4 m for nausea No initials Flovent and Ondansetron were Interviews on 5/18/22 a Manager/staff #1 state | ng dissolve one tab TID pm Nystatin Topical Powder administered. and 5/19/22 the House d: s Ondansetron was in her bedroom because she of nausea at night. | | | | |
| ! | Observation on 5/18/22 PM of client #5's medic and 2 unopened boxes Tourjeo revealed the fol "Refrigerate unope Once in use, do not refr cartridge or pen in use a (below 86) degrees." | between 2:30 PM-2:45 ations revealed 1 opened of Toujeo. All 3 boxes of lowing instructions: ned cartridges or pens, igerate. Store the at room temperature ent #5 stated; he Touleo pen for use, she | | | The second secon | |
| | Interview on 5/18/22 the stated: | House Manager/staff #1 | | | i tonoge au au | |

Division of Health Service Regulation

STATE FORM

6199

MJVC11

If continuation sheet 15 of 34

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING; COMPLETED R MHL092-869 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DESTINY FAMILY CARE HOME 2** 1238 FAIRLANE ROAD **CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XI) COMPLETE TAG PREFIX (FACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG ÖATE DEFICIENCY) V 118 Continued From page 15 V 118 the pharmacy using a cooling system. The Toujeo was maintained in the refrigerator throughout. That was the system in place since she came to work at the facility three months ago. She had not noticed the instructions on the Toujee box prior to this Interview. Interview on 5/20/22 the Pharmacist used by the facility stated: Toujeo once in use should be kept and administered at room temperature. The change in temperatures from hot to cold increases the risk of the insulin breaking down faster. The client may or may not experience discomfort from the insulin being injected cold directly from the refrigerator. Interview on 5/20/22 the Licensee stated: She used to have the physician's order for client #5 to self administer medications. "I can't locate" the self administer physician's order in the record. She could go to client #5's PCP office and obtain a new order. She purchased a notebook for client #5 to write down her own BG readings. She did not know why the notebook could not be located either by staff or client #5. "I have seen the notebook. I last...saw the notebook at the doctor visit before the visit a few weeks ago (5/10/22). It was about on the May 6 visit." She felt maybe client #5 was "nervous at the time of the interview" and did not show the notebook with her BG. III. The following are medication issues regarding client #4. Division of Health Service Regulation STATE FORM

8800

MJVC11

If continuation sheet 16 of 34

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY |
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| | | MHL092-859 | 8. WING | | _ | R |
| NAME OF P | ROVIDER OK SUPPLIER | STREET | ADDRESS, CITY, STATE | = 7D 200F | | 5/23/2022 |
| DESTINY: | FAMILY CARE HOME 2 | | IRLANE ROAD | E, ZIF GODE | | |
| | MINE OAKE HOME 2 | | C 27511 | | | |
| (X4) ID PREFIX | SUMMARY ST | ATEMENT OF DEFICIENCIES | GI I | PROVIDER'S PLAN O | E CORRECTION | 1 |
| TAG | REGULATORY OR I | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | COMP DAT |
| V 118 | Continued From page | 3 16 | V 118 | | · · · · · · · · · · · · · · · · · · · | |
| *** | Review on 5/18/22 of | client #4's record revealed: | | | | |
| | - Admitted: 4/10/12 | 2 | į | | | |
| ************************************** | Allergy | rlipidemia, Anxiety and | | | | |
| + | listed: | signed by the physician | | | | |
| | Garcinia Cambog (Weight Loss) | ia 800mg one tab dally | 9 | | | 1 |
| | Vitamin D3 one ta | th dally | * | | | |
| | Citalopram HBR (| Hydrobromide) 40mg one | *************************************** | | | |
| 1 | tab dally (Anxiety) | | i i | | | |
| İ | Buspirone HCL (F | lydrochloride) 7.5mg one | | | | |
| 1 | iad iwice a day (Anxiel | ty) | | | | ĺ |
| | Solifenancin 5mg (Incontinence) | one tab at night | 1 | | | |
| j ' | Cogentin .5mg on | e tab et nicht | | | | 1 |
| | (Anxiety/Tremors) | o tab at high | W-90-1 | | | |
| | Simvastin 20mg or | ne tab daily (High | A STATE OF THE PERSON OF THE P | | | |
| 10 | Cholesteroi) | • | - | | | \$ |
| | Trazadone 50mg o | one tab at night | | | | } |
| 1 | ramoudine 20mg (GERD) | one tab every evening | | | | į |
| 1 | • | 25mg one tab twice a day | - | | | [|
| 6 | Anxiety & Allergy) | comy one tab twice a day | d dramawan | | | |
| | A. MAR not initialed to dministered: | indicate medication | | | | |
| " | | | arranaments | | | |
| R | eview on 5/18/22 of cl evealed: | lent #4's May 2022 MAR | Management of the Control of the Con | | | |
| Ì., | -no initials to indica | te the PM dosages on the | | | ************************************** | |
| 1 | /th and the AM dosage | es on the 18th were | SERVICE AND THE PARTY OF THE PA | | * Milk-Concession | |
| th | oministered of the about 6/3/21 FI-2. | ve medications listed on | ACCOMPANIES AND AND AND AND AND AND AND AND AND AND | | With monocontains | |
| In | terview on 5/18/22 clie | | Метиминия. Метиминия. | | # nnnonongentale - x v | |
| | She received all her | r medications on the 17th | A CANADA | | | |
| ar | nd the 18th of May. | | An-controller | | ************************************** | |
| mf like mist | Sne could recall the Service Regulation | names of some but not | | | *************************************** | |

810 Ph

MJVC11

If continuation sheet 17 of 34

| | of Health Service Regu | <u>llation</u> | | | PORINI APPROV |
|---|---|--|---------------------------------|---|--|
| STATEMEN AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (A. BUILDING: | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | MHL092-859 | B. WING | | R |
| NAME OF F | PROVIDER OR SUPPLIER | ŠTREFT. | ADDRESS, CITY, STATE | 2 7/p coor | 05/23/2022 |
| DESTINY | FAMILY CARE HOME 2 | 1238 FA | URLANE ROAD | ar 6005 | |
| (X4) ID | SUMMARY OT | ATEMENT OF DEFICIENCIES | NC 27511 | | _ |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D SE COUR ETC |
| V 118 | Continued From page | 17 | V 118 | | |
| | all her medications. | | | | ļ |
| ************************************** | B. Medications not ad | ministered: | | | |
| | 11:00 AM of client #4's evidence of the medic - Vitamin D3 - Hydroxyzine 25 m - Loratadine - Famotidine Interview on 5/18/22 th stated; - She had not given 25 mg and Famotidine because the medication | e House Manager/staff #1 Vitamin D3, Hydroxyzine in the last few days | | | |
| 1 | medications. Observation on 5/18/22 PM of a white bag hand Manager/staff #1 to sur following medications for Vitamin D3 dispenses Hydroxyzine 25mg Loratadine dispenses Famotidine dispenses A second interview on 5 Manager/staff #1 stated | veyor revealed the or client #4 Inside: sed 12/6/21 dispensed 5/11/22 ed 2/8/22 sed 5/1/22 | | | |
| # - C | She did find the abo 4 In the white bag in the "It was an oversight | ove medications for client e staff room. | | | Monocone control of the control of t |
| į M | eview on 5/18/22 of clic IARs revealed the follow Service Regulation | ent #4's March-May 2022 wing pre-typed | | | |

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If continuation sheet 18 of 34

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DESTINY FAMILY CARE HOME 2** 1238 FAIRLANE ROAD CARY, NC 27511 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 Continued From page 18 V 118 medications listed and not initialed as administered: Naphocon A eye drops twice a day prn (Allergies) Ondensetron ODT 4mg pm one tab three times a day Naproxen 250 mg one tab twice a day prn (Pain) Immodium AD 2mg one capsule four times a day prn (Diarrhea) Hydroxyzine HCL 10mg one every 8 hours prn Fluticasone 50mcg spray 2 sprays per nostril pm (Asthma) Observation on 5/18/22 between 10:45 AM and 2:30 PM revealed the above medications were not available in the home to be administered Interview on 5/18/22 the House Manager/staff #1 stated: The pharmacy should be sending some medications. The pharmacist was contacted last week after her doctor's visit that she was out of some medications. "She is out of Flonase, she been out 2 days and eye drops one day" "I've not seen Naproxen, Zofran (Ondansetron), Immodium AD (Loratadine), Hydroxyzine 10mg for her." Interview on 5/19/22 the House Manager/staff #1 stated: She called the pharmacy on 5/18/22. The pharmacist explained he needed to follow up on some of the prn medications to verify the medications were still needed as some were temporary, She had been informed by the Pharmacist on Division of Health Service Regulation STATE FORM

MJVC11

If continuation sheet 19 of 34

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED R MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DESTINY FAMILY CARE HOME 2** 1238 FAIRLANE ROAD CARY, NG 27511 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY V 118 | Continued From page 19 V 118 5/18/22 client #4's eyedrops and Hydroxyzine were on back order. She did not see Naproxen, Immodium and Ondansetron She anticipated some medications not onsite on 5/18/22 to be delivered by the pharmacy on 5/19/22, Interview on 5/20/22 the Pharmacist used by the facility stated the following about client #4's medications: He could not recall when medications were called in for refill. Some medications were requested for refill on 5/18/22 but he was not sure which medications or a specific time of the call. Eye drops usually were on back order for a few weeks or month. Per his records, Ondansetron, "Immodium, Flonase were sent out" on 5/19/22, "Naproxen, the dr (doctor) sent a new order today. Loratadine today will be sent out. Hydroxyzine I need to check on that order" and send it out. D. No Physician's order for Non-prescription medication as well as not noted on the MAR: Observation on 5/18/22 between 10:45 AM-11:00 AM of client #4's medications revealed; Over the counter (OTC) bottle of Ibuprofen 200ma. Ibuprofen was in the same bin as client #4's prescribed medications. Review on 5/18/22 of client #4's record revealed: No physician's orders for Ibuprofen. March-May 2022 MARs did not list Ibuprofen as a medication prescribed or administered. Division of Health Service Regulation STATE FORM

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If continuation sheet 20 of 34

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | SURVEY |
|---|--|---|--|---|---|---------|
| | | | 1. 2010D#4G' | | COMI | PLETED |
| ************************************** | | MHL092-859 | B. WING | | *************************************** | R |
| NAME OF F | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STAT | E 719 CODE | 05 | /23/202 |
| DESTINY | FAMILY CARE HOME 2 | 1238 F. | AIRLANE ROAD | m, mil., October | | |
| | | CARY, | NC 27511 | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL | l ID | PROVIDER'S PLAN OF | CORRECTION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | YON SHOULD BE | COM |
| V 118 | Continued From pag | ge 20 | V 118 | DEFICIENC | :Y) | - |
| ************************************** | Interview on 5/18/22 | the House Manager/staff #1 | V 110 | | | |
| 200000 | erarêd: | | | | | |
| ** | - Client #4 had be | en administered Ibuprofen | | | | i ! |
| | ioi illifior aches, pair | ns and headaches | | | | |
| | administered client # | Ill when the last time she | | | | |
| | - She could not re | call when or how often client | | | | |
| Ì | My nad been adminis | tered (hunrofen | ĺ | | | |
| 1 | She was not awa the MAR. | are the ibuprofen was not on | | | | |
| | She thought if th | e doctor verbally indicated | erons to | | | |
| | in uer to take iphblo: | ien but did not write an | | | | |
| 1 | order, the citent could medication. | be administered the | harman midge | | ! | |
| 1. | | d of the faction of | | | ļ | |
| ŧ | ago, client #4 already | d at the facility 3 months had the Ibuprofen. | Total and the second | | | |
| i c | V. The following are r dient #2. | medication issues regarding | The second secon | | | |
| F | Review on 5/18/22 of | client #2's record revealed: | | | definition p. 4. according | |
| - | Aumittea: 10/10/1 | 2 | | | | |
| R | etardation Coronan: | is, Hypertension, Mental | | | | |
| Н | yperlipidemia | Artery Disease (CAD) and | | | *************************************** | |
| | No physician's ord | lers to self administer | | | n. vonommelena | |
| | FCP notes signed | and maintained by allest | - demonstration | | f | |
| ##2 ## | * 5 FUP dated 4/21/2; | 2- She was seen for | | | | |
| l Sir | rneumatold Arthritis w | vith deformities in hands | The contract of the contract o | | community - i as | |
| on | ice a week" | MTX (Methotrexate) 15mg | | | | |
| 1 | No physician's order | s: | | | | |
| D. | witness am manama a . | | | | | |
| ma | view on 5/18/22 of cl | lent #2's record | *************************************** | | 1 | |
| - | intained by the facilit | y revealed: | *************************************** | | 1 | |
| rev | ealed Meloxicam 7.5 | signed by physician | *** | | ļ | |
| (Ri | neumatoid Arthritis) | my one lab dally | | | ļ | |
| ţ | No other updated or | | 1 | | ! | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | (X2) MULTIPLE | CONSTRUCTION | /V3) DATE | the sine sine | |
|---|---|---|--|--|--|------------------------------|--|
| | America (ACMREK) | | A. BUILDING; | | COM | (X3) DATE SURVE COMPLETED | |
| | | | | | | . | |
| | *************************************** | MHL092-859 | B. WING | | | R | |
| AWE OF B | ROVIDER OR SUPPLIER | STREET | REET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| DESTINY | FAMILY CARE HOME 2 | 1238 FA | IRLANE ROAD | | | | |
| (X4) ID | | GARY, I | IC 27511 | | | | |
| PREFIX | I MON DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF | CORRECTION | · · | |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO | TION SHOULD BE | co | |
| | | | | DEFICIEN | THE APPROPRIATE CY) | ' | |
| V 118 | Continued From pag | e 21 | V 118 | | | <u> </u> | |
| * | - March-April 202 | 2 MARs listed Meloxicam | | | | ļ | |
| *************************************** | 7.5mg one tab dally | as needed | | | | i | |
| | Pavious - France | * ** | | | | | |
| 4 ************************************ | Review on 5/20/22 o | I client #2's list of led by the pharmacy | | | | | |
| • | revealed: | ed by the pharmacy | | | | 1 | |
| | Prescription date | ed 8/1/21 Meloxicam 7.5mg | | | | Ì | |
| | one tab dally as need | led | | | | | |
| ĺ | ntonious as runias | | | | | | |
| | Manager/staff #1 stat | and 5/19/22 the House | | | | | |
| | She attempted to | eu: locate additional physician's | | | | | |
| ļ c | riuers for client #2, | | ***** | | | | |
| į - | No physician's or | ders other than the FL-2 | * decidence | | | | |
|) 0 | lated 7/20/22 were at | the group home | | | | | |
| 1 | nterview on 5/20/22 ti | ne Pharmacist stated; | | | | | |
| · - | When changes w | ere made to medications | A STATE OF THE STA | | į | | |
| h | a himinada cobies (o | the facility. | The state of the s | | | | |
| - | He was not sure v | whan he rant rails | 1 | | } | | |
| | hysician's orders to th | 10 fácility, | | | | | |
| B. | . MAR not current: | | | | occupation and a | | |
| 10 | bservation on 5/18/2: | 2 between 10:30 AM-10:45 | To We was | | - Constitution of the Cons | | |
| 1 | ALLIANGRIGO CITOUT #5.8 | MTX was dispensed | P-Augusta | | Moreover, etc. | | |
| 4/ | 1/44 III a Dupple pack | tet. | Residentify const | | положина с | | |
| 1 | MTX 6 tablets in or | ne compartment | Wethermannen | | * Principal | | |
| 1 | ablets each | remained that contained | | | | | |
| 1 | | | *************************************** | | | | |
| Re | view on 5/18/22 of cl | ent #2's March-May 2022 | to and the state of the state o | | ************************************** | | |
| MA | LA COACSIGO MIX: | | *************************************** | | *** | | |
| to | vvas initialēd as adi | ministered daily opposed | Men water | | d open game. | | |
| 10.6 | once a week for all th | ree months. | • | | | | |
| Ç. 1 | No orders to self adm | inister and an | • | | Ì | | |
| doc | umentation medication | on administered | ** | | , | | |
| i | | } | * | | | | |
| Rev | /lew on 5/18/22 of clie | ent #2's record revealed: | 1 | | | | |
| ir Mealth Se DRM | rvice Regulation | <u> </u> | | | | | |

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If continuation sheet 22 of 34

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---------------------|---|-------------------------------|
| | | MHL092-859 | B. WING | | R |
| NAME OF F | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STAT | E. ZIP CODE | 05/23/202 |
| DESTINY | FAMILY CARE HOME 2 | | IRLANE ROAD | _, | |
| (VALID | Character | CARY, I | IC 27511 | | |
| (X4) ID PREFIX TAG | REGULATORY OR | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | ON SHOULD BE COM |
| V 118 | Continued From page | 22 | V 118 | , , , , , , , , , , , , , , , , , , , | |
| | - No orders to self | administer | | | |
| | orders maintained by Prescription date Strength 4%-30% -10 a day PRN (Pain Relie Prescription 7/19/ unit apply twice a day Review on 5/18/22 of a MAR listed: For Nystatin: May 1st-13th PM as administered. | 21 listed Nystatin 100000 | | | |
| | were marked out three month time frame | | | | The first case |
| of in he he cli | Client #2 did not us Client #2 was at he of the interview. She could not locat to the group home. "I locat | er day program at the time so client #2's Miracle Rub sked in her bedroom " | | | |
| | disen, | pplied it on her feet by | | | |
| | nuary 2022 | e QP stated: cations at this facility in e issues regarding the | | | |
| 1 | Service Regulation | | 1 | | |

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DESTINY FAMILY CARE HOME 2** 1238 FAIRLANE ROAD **CARY, NC 27511** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST 8E PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 Continued From page 23 V 118 This deficiency constitutes a re-cited deficiency. Preview on (5/20/2 afeths/20/22 submitted by the QP revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff will receive immediate training, today on medication storage. Additionally, the facility will provide ongoing training at least weekly for the next 30 days and then monthly afterwards on medication requirements to include appropriate storage of all types of medications. This will continue for a period of 90 days. The training will continue to focus on documentation on MARs, medication storage, ensuring that Dr's (doctor) orders are in place and any other area requiring training to ensure staff competency. Staff will raceive more in depth training by a registered nurse within the next 23 days. Any future deviations from proper medication procedures will result in consequences, up to and including Describe your plans to make sure the above happens. The QP or designee will review MARs, medication administration practices and procedures with the staff at least quarterly and will also conduct observations of medication administration procedures at least once monthly, The administrator will ensure that all medications are stored properly on a weekly basis." Review on 5/23/22 of a second plan of protection dated 5/23/22 submitted by the QP revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Please refer to Plan of Protection dated 5/20/22 for additional plans. The facility administrator will ensure that MARs for each Division of Health Service Regulation

STATE FORM

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If continuation shoot 24 of 34

| AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING; | CONSTRUCTION | (X3) DATE | SURVEY LETED | |
|---|--|---|--|---|---|-----------------|--|
| | | MHL092-859 | B. WING | | } | R | |
| NAME OF P | ROVIDER OR SUPPLIER | CTREET | Annoces and | | 05/ | 5/23/2022 | |
| DESTINA | EAMS V DAME INC | 4330 F4 | ADDRESS, CITY, STATI | E, ZIP CODE | | | |
| merca I (II.) | FAMILY CARE HOME 2 | | IRLANE ROAD NC 27511 | | | | |
| (X4) ID | SUMMARY S | STATEMENT OF OFFICER AND | V 2/5(1 | | | | |
| PREFIX TAG | . (34/263.54) 1344/43771112/67 | R LSC (DENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | COM D | |
| V 118 | Continued From pag | ie 24 | 16.440 | | | ļ | |
| | | | V 118 | | | 1 | |
| *************************************** | chelli are kept currer | nt. Staff members are | | | | ! | |
| - | reduited to sign affer | administration for each | | | | | |
| | indept in inediately at | ter medications have been | | | | ĺ | |
| | which will be | included in the training | | | ! | | |
| *** | WITHOUT WILL DE PROVIDE | d by contracted RN by | 1 | | | | |
| * *** | OF EFROMOS TO | n the Initial POP submitted | | | ļ | | |
| 1 | Or 9/40/44). The facil | IIIV administrator will contact | | | [| | |
| | | client to self administer her | | | 1 | | |
| - | insulin. | aront to seit administer her | | | į | | |
| į. | | ans to make sure the above | | | 1 | | |
| | happens. | and to make sure the above | | | | | |
| | | nee will review MARs, | 1 | | } | | |
| | medication administra | ide wiii review MARs, | - | | j | | |
| | procedures with the or | toff ot least some | Veneral | | | | |
| 1 | VIII also conduct chec | taff at least quarterly and ervations of medication | | | Í | | |
| E | idministration proped | rvations of medication | | | | | |
| 1 | he administrator will | ures at least once monthly. | * | | , | | |
| 8 | I'M Stored property on | ensure that all medications | 4 | | | | |
| i tr | alning le providad on | a weekly basis. After | VI | | • | | |
| , | alning is provided co | munued medication | | | <u> </u> | | |
| a | ction up to termination | essed through disciplinary | | | 1 | | |
| 1 | | | Superior I | | | | |
| Ų | ilents #2, #4 and #5 | n the group home had | | | | | |
| , w | ARITORAS MUICH INCINC | ied Intellectual | | | | | |
| l D | evelopmental Disabili | ity, Down's Syndrome, | | | | | |
| احا | iviciy, GCRU, Mybert | Brision, Dishetoe CAR | | | N. Parameter | | |
| [11, | Ahamhinanus aug Vije | Projes Client #6 and | | | \$ | | |
| ac | iministered insulin wit | though written outbooks at | | | *************************************** | | |
| | Link with the Charles | BENT REIDE VEIVI MAA KALL | | | | | |
| 21 | 2 222 po well == 444 | office BG readings of 362, | WWW | | • | | |
| 11 | 6 reculted in char- | Preadings of 9.9, 10.3, | * | | | | |
| dis | betic medications at | s and increases of her | | | | | |
| #5 | checked har ac | the group home, client | To a second seco | | weet Address | | |
| res | checked her BG and | old not document | | | ** | | |
| RG | charke ware | s made to frequency of | HARAMAPA | | *** | | |
| UC | virecks were not refl | ected on the MAD Oliver | Managerator | | 1 | | |
| | a numbelied boxes of | Toulen was not stored in | | | | | |
| C. 11 | veneu container in the | Prefrigerator appagana su | | | ! | | |
| 24 | *!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!! | and ## KAAA | 1 | | Ì | | |
| v | ervice Regulation | and #5 MARs were not | 4 | | į. | | |

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: A. BUILDING; COMPLETED R MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DESTINY FAMILY CARE HOME 2** 1238 FAIRLANE ROAD **CARY, NC 27511** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE TAC DATE DEFICIENCY Continued From page 25 V 118 initialed immediately after medications were administered. The House Manager/staff #1 initialed the MARs 2-3 days at a time after medications were administered. Client #2's physician's order for Meloxicam was not in her record maintained by the facility. As needed medications such as Naphocon eye drops, Nystatin Powder, Meloxicam, Muscle Rub and Ondansetron were not available at the group nome for clients. This deficiency constitutes a Type A1 rule violation for serious nanion and administrative penalty of \$2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. V 120 27G .0209 (E) Medication Requirements V 120 10A NCAC 27G .0209 MEDICATION REQUIREMENTS V120 All medications will be (e) Medication Storage: stored according to (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, manufacturers instruction or well-lighted, ventilated room between 59 degrees Dr's orders. Any medication and 86 degrees Fahrenheit; stored outside of the storage (B) in a refrigerator, if required, between 36 closet/cabinet will be locked degrees and 46 degrees Fahrenheit. If the as well. Any refrigerated items reingerator is used for food items, medications shall be kept in a separate, locked compartment must be locked in a separate or container. storage container. Staff has (C) separately for each client; been inserviced on this by the (D) separately for external and internal use; QP and the contracted RN (E) in a secure manner if approved by a physician between 5/21 and 6/9/22. for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Division of Health Service Regulation STATE FORM MJVC11

If continuation sheet 26 of 34

PRINTED: 06/02/2022

| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: | CONSTRUCTION | (X3) DATE | SURVEY |
|-------------------|---|--|--|---|--|------------------------|
| | | MHL092-859 | B. WING | | 1 | R |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STAT | | . (05/ | 23/2022 |
| DESTINY | FAMILY CARE HOME 2 | 1238 FA | VIRLANE ROAD | E, ZIP CODE | | |
| ····· | , | CARY, | NC 27511 | | | |
| (X4) ID PREFIX | SUMMARY ST | ATEMENT OF DEFINITIONS | QI | SOMMETIC STANDARD | | |
| TAG | G REGULATORY OR LSC IDENTIFYING INFORMATION) TA | | | PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SQLD'SELL PS 1588 | (XŽ) COMPLI DATE |
| V 120 | Continued From page | ≥ 26 | V 120 | | | ! |
| annum v | Substances Act. G.S. | . 90, Article 5, including any | , , ~ , ~ , | | | 1 |
| min WW | subsequent amendm | ents. | | | | ĺ |
| | | | | ı | | |
| | | | | | j | |
| | | | | | | |
| | | | | | | |
| 1 | This Rule is not met a | as evidenced by: | | | | |
| | Based on observation | , record review and | | | j | |
| i | increa compariment | or container for one of | ** | | 1 | |
| I | hree audited clients (# | (5). The findings are: | *source and | | ļ | |
| 1 | | | | | ļ Ī | |
| 1 | M of the inside of the | 2 between 2:25 PM -2:50 | | | 1 | |
| n | svealed: | raciny's reingerator | ************************************** | | ļ | |
| - | Clients went inside | the refrigerator to make | | | | |
| S | andwiches of to obtail |) a drink of water | | | | |
| , | i unopened box bl | aced in front of the black | | | oo baaran ahaa ahaa ahaa ahaa ahaa ahaa ahaa | |
| j 1,41 | 00 Unit/MI /millititar\" . 28/22, | ed "Toujeo Max Solostr | Academics dispassed | | • mattern monona | |
| - | 2 unopened boxes | in the back of the | - Leaven Market Control | | monotone de la companya de la compan | |
| re | Higerator, These boxe | S WATE Inhalad *Taulan | | | *************************************** | |
| IVŞ | ov mainait ann tiuit/iii. | inioni 24 unita | E-4444 | | ************************************** | |
| dis | bcutaneously at bedti | me." One box had a 2 and the second box was | | | d, tour-page | |
| dis | pensed 3/28/22. | and the second box was | WEATHARD COMMISSION OF THE PERSON OF THE PER | | - may | |
| | | | | | 1 | |
| Int | erview on 5/18/22 clie | nt #5 stated: | Mithrogana | | | |
| | one piaced all her o | pened refrigerated insulin | *** | | İ | |
| box | r r v v v v v v v v v v v v v v v v v v | n box inside of the locked | th-reasona. | | and the second | |
| ; | | | | | ļ | |
| Inte | rview on 5/18/22 Hou | se Manager/staff #1 | | | ļ | |
| stat | .eu. | l e | | | | |
| ago | She started working . | At the dumbing a morning | 1 | | ! | |
| - | Unopened Insulin me | dication were not stored | | | | |
| | rvice Regulation | THE PROOF OF THE PROPERTY AND A PROP | I | | į | |

| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE | SURVEY |
|---|--|--|---|--|--|--------|
| | | | A, BUILDING: | | COMP | |
| | , | MHL092-859 | B, WING | | | ₹ |
| NAME OF F | ROVIDER OR SUPPLIER | STREET | DODESC AIR ALL | | 05/2 | 23/202 |
| DESTINY | FAMILY CARE HOME 2 | | DDRESS, CITY, STATE | ZIP CODE | | |
| | | CARY. N | IC 27511 | | | |
| (X4) ID PREFIX | SI IMMADO E BACH DEFICIEM | TATEMENT OF BETTURENCIES CY MUST BE PRECEDED BY FULL | i Qı i | PROVIDER'S PLAN OF CORRE | | · |
| TAG | REGULATORY OF | LISC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SH | Dill A be | COM |
| | | Action to the second se | TAG | CROSS-REFERENCED TO THE APP DEFICIENCY) | ROPRIATE | DA |
| V 120 | Continued From pag | e 27 | V 120 | | <u> </u> | |
|) ************************************ | In a locked box insid | o the rofrigory | | | | |
| 1 | Since she starte | d, the facility only had one | | | 1 | |
| 1 | TOUR POR TOT THE LOLLIC | lerator. | | | | |
|) All the same | Client #5 used ti | at locked how to store har | | | Ţ | |
| *************************************** | insulin in the refrigera | ator. | | | ł | |
| Pront Passage | Interview on 5/40/22 | the management of the same of | | | Ì | |
| • | stated: | the Qualified Professional | | | į | |
| 1 | - January 2022 wa | is the last time she reviewed | | | ! | |
| | medications at this fa | cility. | | | Ţ | |
| | Prior to this interview. | /iew. sha was not aware the | | | | |
| į 1 | acility old not have a | System to lock uponopod | 1 | | J | |
| | amBararad medicatio | ns. | Man and a second | | j | |
| | She would discus | s the process with the | * *** | | Ì | |
| | Licensee, | | | | ļ | |
| i | nterview on 5/20/55 # | ix lor all the retrigerated | The second | | ļ | |
| i n | redications." | ux for all the refrigerated | - | | 1 | |
| - | | ock box" for the refrigerator. | | | <u> </u> | |
| | s ann an attocked : | O hear this that the made | | | | |
| W | ere not in the locked | box." | | | Annual de la constante de la c | |
| į | landa i ir i mai a | | | | | |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | nis deficiency is cross | referenced into 10A | 44. Table 1 | | * | |
| V | UMU 27G JUZUS Medi | cation Requirements (Tag | Th's debooks. | | 4 | |
| Có | rrected within 23 day | e violation and must be | | | 1 | |
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| V 291 27 | G .5603 Supervised ! | | ************************************** | | Mary (plane) | |
| | - 14440 Gahai Ai280 (| -iving - Operations | V 291 | | ************************************** | |
| 10 | A NCAC 27G .5603 | OPERATIONS | VIII | | Million P. An | |
| (a) | Capacity, A facility | shall some as many than | - | | | |
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| , | Pure 19, 2001, and b | roviding services to man | | | į | |
| 21.754 | 나 이사 에어대는 게 [[[원[[[] | 18. MAV MARtinus ts | | | 1 | |
| Più | VIDE SELVICES at NO III | ore than the facility's | | | | |
| 1100 | Hapa capacity. | i | | | | |
| d Health A | rvice Regulation | Coordination shall be | 1 | | ! | |
| ar (Redill) Qξ | TVICO Regulation | | | | í | |

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: _ MHL092-859 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) YAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY V 291 Continued From page 28 V 291 maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visite outside annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or V291 The administrator is safety issues become a primary concern. responsible for making sure that any orders given by a servergagen --- "; " -- --- aniegs statt staff and monitored This Rule is not met as evidenced by: appropriately. The QP and staff Based on record review and interview the facility falled to coordinate services between the have gone through each client's operator and qualified professionals responsible orders to determine all who are for treatment/habilitation of two of three audited on specialized diets. That clients (#4 and #5). The findings are: information is stored in the MAR book. The administrator A. Review on 5/18/22 of client #4's record and direct care staff will ensure revealed: Admitted: 4/10/12 that the information is shared Diagnoses: Hyperlipidemia, Anxiety and during shift exchange and hiring Allergy of new staff. Pamphlet for 1500 Calorie diet Interviews on 5/19/22 and 5/23/22 the Office Manager at client #4's primary care physician

Division of Health Service Regulation

STATE FORM

MJVC11

If continuation sheet 29 of 34

PRINTED: 06/02/2022

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED MHL092-859 R B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DESTINY FAMILY CARE HOME 2** 1238 FAIRLANE ROAD CARY, NC 27511 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 29 V 291 (PCP)'s office stated: She was familiar with client #4 as the client had been a patient for years She spoke with client #4's PCP, The PCP verified client #4 should be on a 1500 calorie dlet since 7/10/17. The PCP discussed weight loss and client #4 being on a diet during the April 26, 2022 appointment. Per their agency's records client #4's weights ranged as follows: April 26, 2022...221 pounds (lbs) October 5, 2021...222lbs August 9, 2021...223lbs Interview on 5/18/22 the House Manager/staff #1 stated: Started working at the facility 3 months ago None of the clients at the facility were on a diet unless by choice She was not aware client #4 had dietary concerns or restrictions. Interview on 5/18/22 client #4 stated: Her physician talked with her about a diet. "I had to give up white bread." At the group home, she never saw calorie meal plan or anything regarding a dlet. Did not recall anyone at the group home telling her about a diet or losing weight Interview on 5/19/22 the Qualified Professional stated: ----- www. charms to an appointments and shared the information with staff as well as herself Prior to this interview, she was not aware of client #4 being on a diet or a meal plan being recommended. Oivision of Health Service Regulation STATE FORM

MJVC11

If continuation shoot 30 of 34

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING MHL092-859 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 CARY, NC 27511** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XB) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 291 Continued From page 30 V 291 She suggested the Licensee would have more information. Interview on 5/20/22 the Licensee stated: Client #4 told the doctor she wanted to lose weight. "I was not aware she was to be on a diet." "I am aware she want to local valor " recommended the diet," She did not take client #4 to her last doctor's appointment. The House Manager/staff #1 accompanied client #4 to her April 2022 appointment, B. Review on 5/18/22 of client #5's record revealed: Admitted: 1/11/21 Diagnoses: Sacrococcygeal Disorder, Type 2 Diabetes, GERD (Gastroesophageal Reflux Disease), Allergic Rhinitis, Hyperlipidemia, Down Syndrome and Nausea PCP note dated 6/29/21 reflected a follow up visit and address complaint of pain due to fall, "Will check UA (urine analysis) today as she יי בד שבודה (בבשניייי שנייסיסי יו מוויסטיוי אוטופווו א used to treat type 2 Diabetes) and diabetic...She used to not take her levemir every day as directed but now takes it every night." Follow up in 3 months. PCP note dated 11/5/21 reflected a follow up visit. "...A1C is 10.3 today which is slightly up... her glucose has been running around 110 in the AM fasting." Glucose fingerstick checked in office -213. Discontinue (D/C) insulin medications Jardiance and Levemir. Start Glyxambi and Toujeo. D/C BG checks three times a day.

Division of Health Service Regulation

STATE FORM

MJVC11

If continuation sheet, 31 of 34

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: A. BUILDING; _ COMPLETED R MHL092-859 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1238 FAIRLANE ROAD DESTINY FAMILY CARE HOME 2 CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 291 Continued From page 31 V 291 Check BG once in the AM fasting. Follow up in 3 months. PCP note dated 5/10/22 reflected a physical exam was completed and medicald packet reviewed. In addition to change Increases In Glyxambi, Touleo: *A1C is 11.6 today above her normal 10.3 from 11/5/21 visit. "...her glucose has been running around 220 in the AM fasting. She is 3 months late on her follow up... Needs to come in for regular visits as directed. Glucose has increased significantly and if she had come in 3 months earlier as directed this could have likely been avoided." ___Glicore Interview on 5/18/22 the Qualified Professional stated: The Licensee and her husband provided transportation and coordinated all medical appointments for the clients. V736 Facility & Grounds Interview on 5/20/22 the Licensee stated: Maintenance She was not aware client #5 had missed a few follow up appointments. The administrator conducted an V 736 27G .0303(c) Facility and Grounds Maintenance inspection of the facility. All V 736 blown bulbs have been 101. HOND ETG JUDO LUCATION AND replaced. The molding in the EXTERIOR REQUIREMENTS bathroom has been repaired. (c) Each facility and its grounds shall be No leakage was noted. The area maintained in a safe, clean, attractive and orderly has been cleaned, scraped and manner and shall be kept free from offensive odor. painted. Division of Health Service Regulation

STATE FORM

MJVC11

If continuation sheet 32 of 34

| ANDPLAN | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI TIELE / | CONSTRUCTION | | (Vn) 0.504 | |
|----------------|--|--|--|---|--|------------------|--|
| nnu plan | OF CORRECTION | IDENTIFICATION NUMBER: | | CONSTRUCTION | | SURVEY | |
| MMM.4 | | MHL.092-859 | B. WING | *** | | R | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STATE | 710 000 | i05 | <u>/23/2</u> 022 | |
| DESTINY | FAMILY CARE HOME 2 | | IRLANE ROAD | 4, AIT GODE | | | |
| W () | | CARY, I | IC 27511 | | | | |
| (X4) ID PREFIX | SUMMARY S (EACH DESIGIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL | 00 | PROVIDER'S PLAN OF | CORRECTION | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TON SHOULD BE THE APPROPRIATE | COMP DA | |
| V 736 | Continued From 200 | | v / uu | *************************************** | | | |
| | | | a - of statement - or or or or or or or or or or or or or | | | | |
| | This Rule is not met | as evidenced by: | form and the second | | | | |
| İ | interview the facilities | lew, observation and | To American | | | 1 | |
| i | clean, attractive and are: | was not maintained in a safe, orderly manner. The findings | | | | | |
| | Review on 5/18/22 of | f the facility's public file | Minute to the group of the state of the stat | | | | |
| | maintained by Divisio | n of Health Service | Way-ta-management | | | | |
| [] | Negulation (DHSR) o Sanitation report deta | of a local Health Department and 10/27/21 revealed the | nan inner | | | | |
| | following: | o 10/2//21 revealed the | | | | | |
| 1. | 12 total demerits | issued. | | | , , | | |
| " | 1 pt deduction: "(| Ceiling in living room near | | | ļ | | |
| | orick ireplace is peell | ing paint and stained. | - 100 Perm | | oracional de la companya de la compa | | |
| l | eaking. Walls and cal | water damage. No sign of lling should be kept clean | | | | | |
| a | ind in good repair. Re | apair ceiling." | | | } | | |
| P | 'M revealed: | 22 between 2:45 PM- 3:15 | Congression of the Congression o | | And the second s | | |
| - b | earoom. | flb blown in client #5's | | | e de la company e e e e e e e e e e e e e e e e e e e | | |
| fro fir | Stains on ceiling loont entrance to the his oplace. | ocated in living room and ome near the brick | | | * | | |
| - | Both bathrooms ha | ad blown or missing light Liftxtures. | | | ************************************** | | |
| - | SOUTHOUS BAING MISSION AND IMPORTANT AND IMP | e bottom of bathtub not | The second secon | | 144-1 | | |
| De | etween the molding mathtub. | naterial and the base of the | of community——passagency | | İ | | |
| Int | terview on 5/18/22 cli | ent #5 stated: | | | 1 | | |
| ba | She just needed to throom. | replace the bulbs in the | | | | | |
| - la | She did not recall h | now long the bathroom | | | ļ | | |
| YT. | Service Regulation | in the same same sould | | | | | |

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 MHL092-859 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FAIRLANE ROAD **DESTINY FAMILY CARE HOME 2 CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TÁG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 736 Continued From page 33 V 736 bulbs were either missing or blown Interview on 5/18/22 the House Manager/staff #1 stated. No one had informed her of the blown light bulb in clients bedroom, missing/blown bulb in the bathrooms light fixtures and molding not secure in the bathroom. She was not aware of the specifics regarding the cause of the brown stains in the ceiling She would notify management. Division of Health Service Regulation

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If continuation shoet 34 of 34

To: India Vaugha-Rmakes

From: GARNE RATIO

Rq', POC - Destruey -FAIRIANE

DATE: 8/2/22

RECEIVED

By DHSR Mental Health Licensure & Certification at 4:36 pm, Aug 02, 2022