STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL032-389	B. WING			8/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY HOME, INC			ING STREA NC 27704	M ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
		w up survey was completed eficiencies were cited.				
		sed for the following service C 27G .5600A Supervised h Mental Illness.				
	This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.					
V 107	27G .0202 (A-E) Pe	ersonnel Requirements	V 107			
	10A NCAC 27G .0202 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's file.					
	each staff member provides care or se the facility: (1) is at least 1 (2) is able to re follow directions; (3) meets the re competency, work of qualifications for the (4) has no sub	ead, write, understand and minimum level of education, experience, skills and other e position; and stantiated findings of abuse or e North Carolina Health Care				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE COMP	SURVEY LETED
	MHI 033 300		B. WING		R 07/28/2023	
		MHL032-389	b. WING		07/2	8/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DESTINY	HOME, INC		ING STREA , NC 27704	M ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 107	Continued From page 1 (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.		V 107			
	facility failed to have	et as evidenced by: views and interviews, the e a complete personnel record ee audited staff (#1 and #2).				
	records revealed: -Staff #1 had a hire -Staff #1 was hired	as a Habilitation Technician. umentation of a signed job				
	b. Review on 7/27/2 records revealed:	23 of staff #2's personnel				

Division of Health Service Regulation

-Staff #2 had a hire date of 3/2022.

STATE FORM 6899 T8V011 If continuation sheet 2 of 9

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY
71101011	or contribution	BERTH IOMER MORE	A. BUILDING:			
	MHL032-389		B. WING		07/2	₹ 28/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DESTINI	HOME, INC	630 RIPPI	LING STREA	M ROAD		
DESTIN	i HOWE, INC	DURHAM	, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 107	Continued From pa	ge 2	V 107			
	-Staff #2 was hired as a Habilitation TechnicianThere was no documentation of a signed job description for staff #2.					
	and staff #2She was not able to job descriptions for -She confirmed the job descriptions for Interview on 7/27/2: -There was no doct for staff #1 and staff This deficiency has	ed: ns were completed for staff #1 to locate the documentation of staff #1 and staff #2. The was no documentation of staff #1 and staff #2. With the Licensee confirmed: Sumentation of job descriptions				
V 118	27G .0209 (C) Med 10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, inc administered only b unlicensed persons		V 118			
	privileged to prepar	e and administer medications. Iministration Record (MAR) of				

Division of Health Service Regulation

STATE FORM 6899 T8V011 If continuation sheet 3 of 9

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	IDENTIFICATION		A. BUILDING:		COMPLETED	
			D MINO		F	
		MHL032-389	B. WING		07/2	8/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BESTINIV HOME INC. 630 RIPP			ING STREA	M ROAD		
DESTINY HOME, INC DURHAM,			NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests a checks shall be recorded.	red to each client must be kept is administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation				
	facility failed to ensi administered by an a registered nurse, qualified person and administer medicati audited staff (#2). T	views and interviews, the ure medications were unlicensed person trained by pharmacist or other legally d privileged to prepare and ions affecting one of three the findings are:				
	records revealed: -Staff #2 had a hire -Staff #2 was hired	as a Habilitation Technician. umentation of medication				
	a. Review on 7/27/2	23 of Client #1's record				

-Admission date of 2/20/21.

STATE FORM 6899 If continuation sheet 4 of 9 T8V011

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		
	R	
	8/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
DESTINY HOME, INC 630 RIPPLING STREAM ROAD DURHAM, NC 27704		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 118 Continued From page 4 -Diagnoses of Depressive Disorder - Not Otherwise Specified (NOS), Static Encephalopathy, Mild Intellectual Developmental Disability (IDD), and Seizure Disorder. Review on 7/27/23 of Client #1's physician's orders dated 11/23/22 revealed: - Sertraline Hcl (hydrochloric acid) 50 milligrams (mg) (antidepressant) - take 1 tablet (tab) every day Phenytoin 50 mg Infa tab chew (epilepsy) - take 3 tabs every morning Phenytoin 50 mg Infa tab chew (epilepsy) - take 4 tabs every evening Phenotarbital 32.4 mg tab (seizures) - take 1 tab twice dailly Levetiracetam 100 mg tab (seizures) - take 1 tab twice dailly Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 ½ twice daily Levetiracetam 100 mg tab (seizures) - take 1 tab		

Division of Health Service Regulation

STATE FORM 6899 T8V011 If continuation sheet 5 of 9

Division	Division of Health Service Regulation							
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
			B. WING		R			
		MHL032-389	B. WING		07/2	8/2023		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
			ING STREA					
DESTINY HOME, INC			NC 27704	III NOAD				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE		
17.0		,	17.0	DEFICIENCY)				
V 118	Continued From pa	ge 5	V 118					
	- Dulovetine Hcl Dr	60 mg capsule (cap)						
		exiety) - take 2 capsules every						
	day.	Alety) - take 2 capsules every						
		ng tab (antidepressant) - take						
	1 tab every day.	ing tab (antidepressant) - take						
		schizophrenia) - take 1 tab						
	every day.	ornzopriicina) - take i tab						
		(schizophrenia) - take 1 cap						
	at bedtime.	(Schizophichia) - take i cap						
	- Trazodone 100 mg tab (depression) - take 1 tab							
	at bedtime.	g tab (depression) take 1 tab						
		25 mg tab (anxiety) - take 1 tab						
	at bedtime.	o mg tab (anxioty) take i tab						
		late 1 mg tab (involuntary						
	movements) - take							
	movemente, take	r tab twice daily.						
	Review on 7/27/23	of MARs for client #2						
	revealed:							
		MAR - Staff #2's initials were						
	listed as administer							
		MAR - Staff #2's initials were						
	listed as administer							
		MAR - Staff #2's initials were						
	listed as administer							
		-						
	c. Review on 7/27/2	23 of Client #3's record						
	revealed:]		
	-Admission date of]		
	-Diagnoses of Schiz	zoaffective Disorder, Bipolar						
	type.							
]		
		of Client #3's physician's]		
	orders dated 2/6/23]		
		ol 3350 Powder (constipation)]		
		8 ounces of fluid and drink]		
	once daily.]		
		onate 50 micrograms (mcg)]		
		tis) - instill 1 spray in both]		
	nostrils once daily.							
	 Propranolol Exren 	ided Release 60 mg cap (high						

STATE FORM 6899 If continuation sheet 6 of 9 T8V011

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		F	,
	MHL032-389		B. WING		1	8/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY	DESTINY HOME, INC			M ROAD		
			NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 6	V 118			
V 110	blood pressure) - ta - Lithium Carbonate caps at bedtime Trazodone 50 mg at bedtime Gabapentin 300 mat bedtime Benztropine Mes movements) - take Review on 7/27/23 revealed: - July 1 - 27, 2023 I listed as administer - June 1 - 30, 2023 listed as administer - May 1 - 31, 2023 I listed as administer - May 1 - 31, 2023 I listed as administer - May 1 - 31, 2023 I listed as administer - Interview on 7/27/2 - He received medi when hired. Interview on 7/27/2 Professional reveal - Staff #2 had the m training when hired - She could not local medication administration.	ake 1 cap every day. 2 300 mg cap (mania) - take 3 tab (depression) - take 1 tab ng tab (seizures) - take 1 cap 1 mg tab (involuntary 1/2 tab twice daily. of MARs for client #3 MAR - Staff #2's initials were ring the medication. MAR - Staff #2's initials were ring the medication. MAR - Staff #2's initials were ring the medication. 3 with staff #2 revealed: cation administration training 3 with the Qualified ed: edication administration	V 110			
	Interview on 7/27/2 -There was no doc	stration training for staff #2. 3 with the Licensee confirmed: umentation of medication ing in the personnel folder for				
		been cited 2 times since the				

6899

Division of Health Service Regulation STATE FORM

within 30 days.

T8V011 If continuation sheet 7 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED	
		MHL032-389	B. WING			R 28/2023
	NAME OF PROVIDER OR SUPPLIER DESTINY HOME, INC 630 RIPP DURHAM			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor. This Rule is not me Based on observati and its grounds we safe, and attractive Observation on 7/2 revealed: -Kitchen area: -Windowpane ov with black marks. -Cabinets were such that is a considered in the constant of the constan	d its grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: on and interview, the facility re not maintained in a clean, manner. The findings are: 7/23 at about 9:00 am rer kitchen sink was stained stained with black marks. rk, approximately 24" x 10" in laundry room was stained, wish in color. pring leaned against living leading to the hallway was a sized light brownish/yellowish sixth marks, approximately 24",	V 736			

Division of Health Service Regulation

STATE FORM 6899 T8V011 If continuation sheet 8 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	MHL032-389		B. WING		F 07/2	8 8/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY	HOME, INC		ING STREA	M ROAD		
DURHAN			NC 27704			
(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 APPROFILIENCY)	D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 8	V 736			
	-Baseboards wer brownish/blackish n					
	-Bathroom #2: -Baseboards wer brownish/blackish n					
	-Backyard Area: -Two ply wood boards, approximately 5' x 5' on ground beside the deckMetal bed railing leaning against deckFull size headboard laying under deck.					
	-Front right side of the home next to driveway: -Half of a cinder block on groundFive small (grocery store) plastic bags laying on groundTwo soda cans and one plastic soda bottle laying on ground.					
	Interview on 7/27/23 with the Qualified Professional revealed: -She was aware of most of the maintenance issues with the group homeShe had most of the repairs completed after the last survey in 2022She acknowledged the facility and its grounds were not maintained in a clean, safe, and attractive manner					
		been cited 2 times since the /21 and must be corrected				

6899

Division of Health Service Regulation STATE FORM

T8V011 If continuation sheet 9 of 9