Division of Health Service Regulation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME OF	220 4254 00 61122 150				
MARIE UF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
DESTINY	FAMILY CARE HOM	E 2 CARY, NO	LANE ROAL 27511		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERÊNCED TO THE APPRO DEFICIENCY)	DBE COMPLETE
V 000	INITIAL COMMENT	rs	V 000		
	completed on July a unsubstantiated (in	nt and follow up survey was 22, 2024. The complaints were take #NC00217216 & ciencies were cited.			·
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.			
	census of 5. The su	sed for 6 and currently has a urvey sample consisted of clients and 1 former client.			. '
V 105	27G .0201 (A) (1-7)	Governing Body Policies	' V 105		
	10A NCAC 27G .02 POLICIES	01 GOVERNING BODY			
	facility or service sh written policies for t (1) delegation of ma operation of the fac (2) criteria for admit	anagement authority for the ility and services; ssion;	•	V105 The facility administrator applied for the CLIA walver and yet received the walver. Adminis will follow up.	i has not
	(B) time frames for (5) client record ma	arge; ssments, including: n the assessment; and completing assessment. nagement, including: zed to document;			
	(B) transporting rec (C) safeguard of red defacement or use	ords; cords against loss, tampering, by unauthorized persons; cord accessibility to			
	(E) assurance of co(6) screenings, which(A) an assessment problem or need;	infidentiality of records.		,	,
livision of He	alth Service Regulation	or whence or not the islandy		18°-	
		ER/SUPPLIER REPRESENTATIVES SIGN	PALLITA	TITLE	(X6) DATE

STATE FORM

Division	of Health Service Re	egulation			FOR WITH APPROVED
STATEMEN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
CHAPT L TEAM	1 OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, !	STATE, ZIP CODE	<u> </u>
DESTIN	Y FAMILY CARE HOM	E 2 1238 FAIF	RLANE ROAD	D	
		CARY, NC	; 27511		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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 COMPLETE
V 105	Continued From pa	ige 1	V 105		
	can provide service needs; and (C) the disposition, recommendations; (7) quality assurance activities, including: (A) composition and assurance and quality and approprincluding delineation utilization of service (D) professional or a requirement that sprofessionals and poshall be supervised that area of service; (E) strategies for im (F) review of staff quality and programmation made treatment/habilitatio (G) review of all fata were being served in residential programs (H) adoption of standard purpose, "applicable means a level of coreference to the premethods, and the displacements."	including referrals and ce and quality improvement d activities of a quality dity improvement committee; essurance and quality onitoring and evaluating the fateness of client care, on of client outcomes and es; clinical supervision, including staff who are not qualified provide direct client services by a qualified professional in c; inproving client care; qualifications and a e to grant	VIOL		

Division	of Health Service Re	egulation			PORIMAPPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` `	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME OF	PRÓVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
DESTIN	FAMILY CARE HOM	4990 EAII	RLANE ROA		
**************************************	FAMILI OAKE FRAN	CARY, NO	27511		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE COMPLETÉ
V 105	Continued From pa	ge 2	V 105		
	failed to develop an standards that ensu programmatic performance standards for the C Improvement Amenare: Review on 6/18/24 revealed: Admitted 8/10/2 Diagnoses of Ty Schizoaffective Dischizoaffective Dischizoaffective Dischizoaffective Dischizoaffective Dischizoaffective on a physician ordesugar (BS) four time. During interview on Professional reported: She had discuss Licensee the Administrate obtaining the CLIA versions and did not had not obtained the During interview on reported:	view and interview, the facility of implement adoption of a perational and ormance meeting applicable LIA (Clinical Laboratory adments) waiver. The findings of a partial record for client #3 and applicable applicable and applicable decided and applicable and ap			
	- The facility did r	not have a CLIA waiver w she needed a CLIA waiver			

ANY OF AN OF COORDINATE INC. THE THE CATTON AND IMPER-		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
	MHL092-859	B. WING		R 07/22/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
	1238 FAIR	LANE ROAL		
DESTINY FAMILY CARE HOME 2	CARY, NO	27511	· · · · · · · · · · · · · · · · · · ·	
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 111 Continued From page	≥ 4	V 111	,	
failed to ensure admis completed for 1 of 3 a 2 former clients (FC # Review on 6/18/24 of revealed: - Admitted 8/10/23 - Diagnoses of Typ Schizoaffective Disord Hyperlipidemia - No documentation assessment Review on 6/20/24 of - Admitted 6/5/24 a - Diagnoses of Pos Intellectual Developm Depressive Disorder & No documentation assessment Interviews on 6/19/24 Professional reported - Client #3 was admission - Knew client #3's a admission - Knew client #3's a	ew and interview, the facility ssion assessments were audited clients (#3) and 1 of #6). The findings are: a partial record for client #3 be 2 Diabetes Mellitus, der, Hypothyroidism & m of an admission FC #6's record revealed: and discharged 6/6/24 esttraumatic Stress Disorder, mental Disorder, Major & Asthma m of an admission & 6/20/24 the Qualified I:			

Division	of Health Service Re	gulation	***		
AND ALL OF ADDROGRAMAL INCOME TO THE STREET BOOK		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-859	B. WING		R 07/22/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
DESTIN	FAMILY CARE HOM	E 2 1238 FAIR CARY, NO	LANE ROAL 27511	`	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DIBE COMPLETE
V 111	discharged from the Interviews on 6/18// reported: - Was responsib admission assessment She completed assessment, but she client record - FC #6's admission process admission assessment completed because the completed because the completed second completed sec	e facility 24 & 7/22/24 the Administrator le for completing client's	V 111		
V 118	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 pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength,	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the sluding injections, shall be by licensed persons, or by a trained by a registered nurse, r legally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kept a sadministered shall be ely after administration. The	V 118	V118 – As of 7/23/24, the facilit has completed training for all employees working at this partic home on following Dr's orders a written, medication documentation ensuring the MARs are kept curtas medications are administered proper medication disposal. The administrator will monitor.	cular as ion, rent and

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Division	of Health Service Re	egulation			(OTHER) TOVED
		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	,	COMPLETED
			}		R
		MHL092-859	B. WING	······	07/22/2024
NAME AE I	PROVIDER OR SUPPLIER	OTORET AD		STATE, ZIP CODE	
INMINIC UT	"MOVIDER ON SEFTER				
DESTIN	FAMILY CARE HOM	E 2 CARY, NO	LANE ROAI	•	
23.2.51.375	SI MALES COV C'YO	TEMENT OF DEFICIENCIES	1	MANUARCHIA PARA AREAN MANUARANE	4. N. I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE
V 118	Continued From pa	ge 6	V 118		
	(D) date and time the (E) name or initials drug. (5) Client requests checks shall be reciple followed up by a with a physician. This Rule is not me Based on observation interview, the facility medications on the 1 of 3 audited client Review on 6/18/24 revealed: Admitted 8/10/2 Diagnoses of T Schizoaffective Dise Hyperlipidemia Physician order Notice 10/10/23: check day (QID) (Diabetes 6/17/24: Humal meals based on slic is 80-150 take 8 U, take 14 U, 301-350 U (Diabetes) 9/20/24: Lantus subcutaneously in the state of the subcutaneously in the state of the support of th	ne drug is administered; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation appointment or consultation written order of a physician for the findings are: of a partial record for client #3 and year 2 Diabetes Mellitus, order, Hypothyroidismn& and sugar (BS) four times a solog 200 units (U) Inject before ding scale: If blood sugar (BS) 151-200 take 10 U, 251-300 take 16 U & 351-400 take 18 in 100U inject 38U the evening (Diabetes)			
	June 2024 MARs re - No documented				

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PRINTED: 07/29/2024 FORM APPROVED

Division	of Health Service Re	egulation			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S'	TATE, ZIP CODE	
DESTINY	FAMILY CARE HOM	E 2 1238 FAIR CARY, NC	LANE ROAD 27511	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
V 118	Continued From pa	ge 7	V 118		
	- BS readings we 6/4/24, and QID from No BS readings 8/10/23-6/3/24 Observation & interclient #3 reported: - Checked her B Monitored her I was to her photoecause her BS was too highway was prescribed daily - Staff recorded Client #3 went the BS reading not Couldn't recall located	s were documented from rview at 12:18pm on 6/18/24 IS QID BS closely with her physician sysician ever two weeks as "so high" the wore daily that alerted her if			
	- She checked c 4pm & 8pm	reported. Hient #3 BS QID at 8am, 11am, He BS readings in client #3's			
	 Staff checked of documented the re Couldn't recall was located that co prior to June 2024 Client #3 had a 	4 the Administrator reported: client #3's BS QID and adings in a BS log where client #3's old BS log ontained client #3's readings a doctor's appointment on 6 log could have been left at			

<u>Divis</u>	ion of Health Service R	egulation			PURM APPROVED
	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(XX) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME	DF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	<u> </u>
DEST	INY FAMILY CARE HOM	4939 EAII	ROA	,	
		CARY, NO	27511		AN AND AND AND AND AND AND AND AND AND A
(X4) PREF TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 1	19 Continued From pa	ige 8	V 119		
٧	119 27G .0209 (D) Med	lication Requirements	V 119		m ś
	10A NCAC 27G .02 REQUIREMENTS (d) Medication disp (1) All prescription medication shall be guards against dive (2) Non-controlled of by incineration, for system, or by transidestruction. A reconshall be maintained Documentation shall be maintained Documentation rame, so date and method, the disposing of medical witnessing destruct (3) Controlled substances Act, G. subsequent amend (4) Upon discharge remainder of his or disposed of prompt expected that the pot the facility and in drug supply shall not reconstruction.	cosal: and non-prescription disposed of in a manner that ersion or accidental ingestion. substances shall be disposed lushing into septic or sewer fer to a local pharmacy for d of the medication disposal by the program. It specify the client's name, strength, quantity, disposal he signature of the person ation, and the person ion. tances shall be disposed of in the North Carolina Controlled S. 90, Article 5, including any		V119 — As of 7/23/24 medication was completed for the staff in the Expired and spilled/loose medicated be disposed of by flushing into a sewer system (with a witness), of to a local pharmacy for destruction of the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if compared to the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by the program if the medication disposal shall maintained by	nis home, ations shall a septic or or by transfer ion. A record be
	interview, the facility	et as evidenced by: on, record review and / failed to dispose of g 1 of 3 audited clients (#5).		-	

Division of Health Service Regulation					
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME OF 6	PROVIDER OR SUPPLIER	\$TREET AD	DRESS, CITY, 5	STATE, ZIP CODE	
DESTINY	FAMILY CARE HOM	E 2 1238 FAIR	RLANE ROAL		
	S-MARINE - MARINE - M	CARY, NO	27511		
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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)	LD BE COMPLETE
V 119	Continued From pa	ge 9	V 119		
	- Admitted: 7/28// - Diagnoses: Sch Hyperlipidemia, Typ Tobacco Disorder - FL2 dated 6/4/2 - Risperidone half tablet by mouth (Schizophrenia) - Risperidone tablet by mouth at b - Benztropine mouth at bedtime (Tobservation at appr 6/18/24 of client #5': - A pill packet lab contained small white - A pill packet lab contained small beige - 4 small white over inside of the Benztro the bottom of the medication bin were - 1 small beige ro identical to the pills it packet, located at the bin Interview on 6/18/24 - been at the facil - she took medical Interview on 6/18/24 - she was responsibins - she checked the	nizoaffective Disorder, be II Diabetes Mellitus & 24 with the following: e 3 mg (milligrams) take one in the morning e 3 mg take one and one half bedtime e 1 mg take one tablet by Tremors) roximately 11:30am on selection bin revealed: beled for Benztropine 1 mg that beled for Risperidone 3 mg that ge round pills val pills, identical to the pills opine pill packet, located at edication bin oval pills in the bottom of the broken in half bund pill, broken in half, inside the Risperidone pill he bottom of the medication daily as prescribed the Administrator reported: sible for checking medication			

<u>Division</u>	of Health Service Re	equiation			FORM APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 "	PLE CONSTRUCTION	(X3) DATE SURVEY
	The second secon	POSTA NA LONG FOR A REGISTER OF THE	A BUILDING	<u> </u>	COMPLETED
		MHL092-859	B. WING_		R 07/22/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CTTY,	STATE, ZIP CODE	W I I I I I I I I I I I I I I I I I I I
DESTIN	FAMILY CARE HOM	EZ	RLANE ROA	ND	<i>:</i>
		CARY, NO	27511		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE COMPLETE
V 119	Continued From pa	ge 10	V 119		
	popped out of the p find them so they po - client #6 did not	ed them and Risperidone pills were ill packets but staff could not opped out another pill miss any scheduled enztropine or Risperidone			
	provides residential home environment values services is the rehabilitation of individuals, a development or a substance abus supervision when in (b) A supervised livit the facility serves ell (1) one or more (2) two or more (2) two or more (3) two or more (4) two or more (5) two or more (6) Each supervised licensed to serve a serves adults whose illness but may also be (6) "B" designated below: (1) "A" designated below: (2) "B" designated below: (3) "C" designated below: (4) "B" designated below: (5) "B" designated below: (6) "C" designated below: (7) "C" designated below: (8) "C" designated below: (9) "C" designated below: (1) "C" designated below: (2) "B" designated below: (3) "C" designated below:	Of SCOPE g is a 24-hour facility which services to individuals in a where the primary purpose of care, habilitation or viduals who have a mental ental disability or disabilities, disorder, and who require the residence. Ing facility shall be licensed if	V 289	V289 - The surveyed clients vereassessed to determine the appropriateness of the current placement. For one of the client an exemption/waiver for one clients. It is the responsibility administrator to involve the Q and/or to let the QP know whethere's a new admission.	t ents of the of the IP
	alth Service Regulation	TOWNS ARE WELL OF THE PROPERTY WAS USED !	,		
vision of He.	aun Service Regulation				

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STAMEBET OF DEFICIENCES NATION PLAN OF CORRECTION MHUB32-659 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JUP CODE. 1236 FARELANE ROAD CARY, NC 27511 PREPARABLY CARE HOME 2 1236 FARELANE ROAD CARY, NC 27511 PROVIDERS PLAN OF CORRECTION PREPARAMETERS PLAN OF CORRECTION ROAD BY A CARY, NC 27511 PREPARAMETERS PROVIDER OR SUPPLIER 1236 FARELANE ROAD CARY, NC 27511 PROVIDERS PLAN OF CORRECTION ROAD BY A CARY, NC 27511 V 289 Continued From page 11 Services minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility which sorves adults whose primary diagnoses is mental illness but may also have other diagnoses; or each clift cliff of the many also have other diagnoses; or each cliff cliff of the many also have other diagnoses is mental illness but may also have other diagnoses; or each cliff cliff of the many also have other diagnoses is mental illness but may also have other diagnoses is mental illness but may also have other diagnoses; or each cliff of the many also have other diagnoses; or each cliff of the many also have other diagnoses is mental illness but may also have other diagnoses is mental illness but may also have other diagnoses is developmental diagnoses is developmental diagnoses is an ental illness but may also have other diagnoses in the same provides the script of the many also have other diagnoses is developmental diagnoses is an ental illness but may also have other diagnoses is developmental diagnoses is developme	Divisio	n of Health Service R	egulation			FORM APPROVED
MHI. D32-659 MHI. D32-659 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1236 FAIRLAND ROAD CARY, NC 27511 FROM STATE PLAN OF CORRECTION SHOULD BE CONSUMED BY TAKE PREFIX (EACH DEFICIENTY MUST BE PROCEDED BY TAKE) PREFIX (EACH DEFICIENTY) PREFIX (EACH DEFICENTY) PREFIX (EACH DEFICENTY)	STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	TYPE DATE SUBJEY
MANDE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1238 FARELANE ROAD CARY, NO. 27511 CARY, NO. 27511 V 289 Confinued From page 11 serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "I designation means a facility which serves adults whose primary diagnosis is nentral illness but may also have other disabilities, or three adult clients whose primary diagnoses is mentral illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities hot live with a family and the family provides the service. This facility shall be exempt from the following rules: I CAN CCAC 276, 2020 (a)(1),21,31,(4),(5),(4),(6),(6),(7),(7),(7),(7),(7),(7),(7),(7),(7),(7	AND PLA	IN OF CORRECTION	IDENTIFICATION NUMBER:	ı		
MAME OF PROVIDER OR SUPPLIER DESTINY FAMILY CARE HOME 2 1238 FARRLANE ROAD CARY, NO. 27511 OV4) ID PREST (RACH DEPRICIES OF MATERIAL OF DEPRICIES OF FULL PREST (RACH DEPRICIES OF MATERIAL OF DEPRICIES OF FULL PREST (RACH DEPRICIES OF MATERIAL OF DEPRICIES OF FULL PREST (RACH DEPRICIES OF MATERIAL OF DEPRICIES OF FULL TAG V 289 Continued From page 11 serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E' designation means a facility which serves adults whose primary diagnoses is mental illness but may also have other diagnoses; or (6) "F' designation means a facility in a private residence, which serves no more then three adult clients whose primary diagnoses is mental illness but may also have other diagnoses; or (6) "F' designation means a facility in a private residence, which serves no more then three adult clients or three minor clients whose primary diagnoses is mental illness but may also have other disabilities or three minor clients whose primary diagnoses is mental illness but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1)(2)(4)(4), (5)(4)(4)(5)(6)(4)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(4)(6)(1)(6)(1)(4)(6)(1)(6)(1)(4)(6)(1)(6					1	
DESTINY FAMILY CARE HOME 2 1236 FARLANE ROAD CARY, NC 2751 (A49) D SHAMMARY STATEMENT OF DEPOISACIES THE			MHL092-859	B. WING		
DESTINY FAMILY CARE HOME 2 Q491D PREFIX RAC SUMMARY STATEMENT OF DEPICIENCIES (RACH DEPICIENCY MLST BE PRECEDED BY FULL TAG PREFIX TAG CARY, NO 27511 PREFIX TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG CROSS-REFERENCED TO THE TAG	NAME OF	F PROVIDER OR SUPPLIER	STOFETA	DOEGO ALLA	Part of the second seco	
CARTY, NC 27511 PROVIDER'S ATTACHER'S DEPROSACIES (EACH DEPROSACIES (EACH DEPROSACY MUST BE PRECEDED BY FULL TAGE (EACH DEPROSACY MUST BE PRECEDED BY FULL TAGE (EACH DEPROSACY MUST BE PRECEDED BY FULL TAGE (EACH DEPROSACY OR A PRECEDED BY FULL TAGE OF CONNECTION A PRECEDED BY FULL TAGE OF CONNECTION AND A PRECEDED			2 10 10 10 10 10 10 10 10 10 10 10 10 10			
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V 289 Continued From page 11 serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients or three minor clients whose primary diagnoses is mental illness but may also have other diagnoses; or (6) "F" designation are not three minor clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a) (1) (2),(3),(4),(5)(1),(3),(1);(5),(6),(7) (A),(B),(E),(F),(G),(H),(B),(H),(B),(F),(F),(G),(H),(B),(F),(F),(G),(H),(B),(F),(F),(G),(H),(B),(F),(F),(G),(H),(B),(F),(G),(H),(B),(F),(G),(G),(G),(G),(G),(G),(G),(G),(G),(G	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		DECIMENT DI AM OF COCCE	
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Division of Health Service Regulation FORM APPROVE					
STATEME	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY
ANNU TERM	1 OF COMMECTION	IDENTIFICATION NUMBER:	1	3:	COMPLETED
					R
		MHL092-859	B. WING		07/22/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	. STATE, ZIP CODE	
DESTIN	Y FAMILY CARE HOM		RLANE ROA		
		CARY, NO			
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	מו _	PROVIDER'S PLAN OF CORRECT	CTION (X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	OULD RE COMPLETE
		× , , , , , , , , , , , , , , , , , , ,		DEFICIENCY)	A CALLESTEE AND AND THE
V 289	Continued From pa	ige 12	V 289		**************************************
ı		•			
!	Review on 6/18/24	of the facility's license		,	
l	revealed:	_			
1	- The facility was	licensed for Supervised	- The state of the		
1	Living for Adults with	th Developmental Disabilities			
j	Review on 6/18/24	of a partial record for client #3			
	revealed:				
	- Admitted 8/10/2			occupation of the second of th	
	- Diagnoses of S	chizoaffective Disorder, Type		Parameter	
j	Il Diabetes Mellitus,	, Hypothyroidism &			
	Hyperlipidemia No documentati	ion of an Intellectual		· Caranterior in the Caranterior	
	Developmental Disc	order (IDD) diagnosis		distributed by the state of the	
		_		\$\$	
1	Review on 6/18/24 (of client #5's record revealed:		**************************************	
	- Admitted 7/28/2			The state of the s	
	- Diagnoses of Sc	chizoaffective Disorder, e Il Diabetes Mellitus &		Account	
	Tobacco Disorder	e ii Diabetes Meintus &		A Paraconnum	
		ion of an IDD diagnosis			
	Interview on 6/18/24	the Qualified Professional		THE PARAMETER STATE OF	
	(QP) reported:				
	Teviewing clients' ref	or was responsible for ferrals and admitting clients			
	into the facility	errais and admining crients			
4	- Client #3 was ac	dmitted on 8/10/24			
	 Didn't know if cli 	ient #3 had a diagnosis of			
	IDD				
	- I hought client #	5 had an IDD diagnosis			
	#6's IDD diagnosis	cumentation showing client	***************************************		
	TO VILLE GREGITAGE		1		
	Interviews on 6/18/2	4 & 7/22/24 the Administrator	##-#**********************************		
	reported:	I	**************************************		
	- The facility was I	licensed to care for clients	***************************************		
'	with developmental of	Jisabilities			
, '	 vvas responsible referrals and admittir 	e for reviewing clients' ng clients into the facility			
	alth Service Regulation	ig citerias find the lacking			

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL092-859	B. WING		R 07/22/2024		
			DRESS, CITY, S	STATE, ZIP CODE			
DESTIÑY	Y FAMILY CARE HOM	E 2 1238 FAIR CARY, NO	LLANE ROAL 27511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC EDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DRE COMPLETE		
V 289	- Couldn't recall diagnosis	if client #3 had an IDD she would involve the QP in	V 289				
V 366	10A NCAC 27G .06 RESPONSE REQUIRESPONSE REQUIRESPONSE REQUIRESPONSE REQUIRESPONSE AND Implement written presponse to level I, shall require the proof individuals involved (2) determining of individuals involved (3) developing measures according timeframes not to expecified timeframes (4) developing to prevent similar in specified timeframes (5) assigning for implementation preventive measures (6) adhering set forth in G.S. 75. 42 CFR Parts 2 and (7) maintaining Subparagraphs (a) (b) In addition to the Paragraph (a) of the shall address incide regulations in 42 C (c) In addition to the Paragraph (a) of the Paragraph (b) of the Paragraph (b) of the Paragraph (b) of the Paragraph (b) of the Paragraph (c) of the Paragraph (c) of the Paragraph (c) of the Paragraph (c) of the Paragraph (d) of the Parag	IREMENTS FOR B PROVIDERS B providers shall develop and policies governing their Il or Ill incidents. The policies ovider to respond by: to the health and safety needs red in the incident; ng the cause of the incident; g and implementing corrective g to provider specified exceed 45 days; g and implementing measures recidents according to provider responsible of the corrections and	V 366	V 366 Incident Response Requirements The policy for incident report requirements was reviewed immediately by the administrational review was concerned by the QP on 7/23/24. The responsible and defined level 1, incidents, reporting requirement procedures for incidents reporting. The direct care states responsible for completing level 2 & 3 incidents and the QP is responsible for completing level 2 & 3 incidents must be reported immediately to the QP or administrator when QP is not available. The administrator understands that any report infinity, DSS, police, allegation neglect, abuse or exploitation be followed up on and reported appropriate entities immediate the manner identified in the poland procedures and/or regulation	rator. mpleted view 2 and 3 ents and nt ff is vel 1 nsible cidents. d volving us of must d to elicies		

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Division of Health Service Regulation						
AND DEALER CONDECTION INTERIOR AT INTERIOR AND A SERVICE OF THE SE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-859	B. WING		R 07/22/2024	
NAME OF F	PRÓVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DESTINY	FAMILY CARE HOM	E 2 1238 FAIR CARY, NO	LANE ROAL 27511	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE COMPLETE	
	their response to a while the provider is or while the client is The policies shall re by:	nent written policies governing level III incident that occurs s delivering a billable service s on the provider's premises. equire the provider to respond				
	(1) immediate by: (A) obtaining (B) making a (C) certifying (D) transferring review team; (2) convening review team within internal review team within internal review team who were not responsible with direct professions services at the times review team shall confolows: (A) review the determine the facts and make recommon occurrence of future (B) gather off (C) issue writh within five working or preliminary findings LME in whose catcle located and to the Lift different; and (D) issue a firm owner within three off in all report shall be catchment area the LME where the clies.	the client record; photocopy; the copy's completeness; and ag the copy to an internal 24 hours of the incident. The a shall consist of individuals yed in the incident and who le for the client's direct care or onal oversight of the client's of the incident. The internal complete all of the activities as a copy of the client record to and causes of the incident endations for minimizing the e incidents; her information needed; then preliminary findings of fact days of the incident. The is of fact shall be sent to the hment area the provider is all written report signed by the months of the incident. The sent to the LME in whose provider is located and to the int resides, if different. The shall address the issues				

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DIVISION	of Health Service Re	egulation	Division of Health Service Regulation							
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED					
					R					
		MHL092-859	B. WING		07/22/2024					
NIABAE AE		OTDECT AN	UBESS VITA S	TATE, ZIP CODE						
WWIE UP	PROVIDER OR SUPPLIER		URESS, CITT. S RLANE ROAD	·						
DESTIN	Y FAMILY CARE HOM	E 2 CARY, NO								
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V 366	Continued From pa	ge 15	V 366							
	include all public do incident, and shall a minimizing the occa all documents need available within three within three months to suit (3) immediat (A) the LME rarea where the ser Rule .0604; (B) the LME different; (C) the provider; (D) the Depart (E) the client applicable; and	emal review team, shall ocuments pertinent to the make recommendations for arrence of future incidents. If ded for the report are not see months of the incident, the provider an extension of up to bomit the final report; and ely notifying the following: responsible for the catchment vices are provided pursuant to where the client resides, if der agency with responsibility updating the client's ifferent from the reporting rement; 's legal guardian, as authorities required by law.								
	Based on record refailed to convene a within 24 hours of a issue a written prel Local Management Organization (LME of the incidents. The A. Review on 6/20/	et as evidenced by: eview and interview, the facility meeting of internal review a level II incidents and failed to iminary finding of fact to the t Entity/Managed Care /MCO) within five working days the findings are: 24 of client #1's hospital lated 4/10/24 revealed:								

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Division of Health Service Regulation						
AND DIAN OF CODECTION INDESTRUCTION AND INDESTRU		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		MHL092-859	B. WING		R 07/22/2024	
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NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	-		
DESTINY	FAMILY CARE HOM	E 2 CARY, NO	LANE ROAD 27511	100 A		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST 88 PRECEDED 8Y FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 366	Continued From pa	ge 16	V 366			
	unwitnessed fall. Si was having right hip	(client #1) had an he was found on the floor. She o pain. X-rays in ER) show a right femoral neck				
	B. Review on 6/20/24 of a police report dated 6/6/24 revealed: - "This report is in regards to an Involuntary Commitment Service at 1238 Fairlane RdSuspect (Former Client (FC) #6) was committed involuntarily (IVC) at [local hospital]."					
,	revealed: - No documenta: meeting for client #	tion of a written preliminary				
	Professional (QP) r - Client #1 fell ouright hip - Management udiscuss incidents, blong time - Was responsibly preliminary findings incident - The Administra	at of her bed and broke her sed to hold meetings to but they haven't done it in a le for submitting written to fact within 5 days of the stor said that she had notified				
	- Was unaware of Interviews on 6/18// - Convened a modient #1's hip fraction meeting for FC #6's - "The QP should be a should	she "failed to follow up" of the incident involving FC #6 24 the Administrator reported: eeting of internal review for ure, but didn't convene a s IVC d answer questions about g" and notifying the LME/MCO				

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Division	of Health Service Re	gulation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL092-859	B. WING		07/22/2024
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 367	Continued From pa	ge 18	V 367		
	(1) the provio	ler has reason to believe that			
	* *	d in the report may be			
		ling or otherwise unreliable; or			
		ler obtains information			
	required on the inci unavailable.	dent form that was previously			
		B providers shall submit,			
		a LME, other information			
	obtained regarding	the incident, including:			
		ecords including confidential			
	information;				
		y other authorities; and ler's response to the incident.			
		B providers shall send a copy			
		nt reports to the Division of			
	Mental Health, Dev	elopmental Disabilities and			
		Services within 72 hours of			
		the incident. Category A			
		d a copy of all level III			
		a client death to the Division of julation within 72 hours of			
		the incident. In cases of		A Administration of the Control of t	
		seven days of use of seclusion			
		vider shall report the death			
		quired by 10A NCAC 26C			
		AC 27E .0104(e)(18).			
		B providers shall send a			
		he LME responsible for the ere services are provided.			
		submitted on a form provided			
		a electronic means and shall			
		nformation as follows:			
		on errors that do not meet the	:	or the state of th	
		Il or level III încident;		Vended-American	
		interventions that do not meet		The state of the s	
		evel II or level III incident;	1	Laboration	·
		of a client or his living area; of client property or property in		Personal	
	the possession of a				
	mos prosessesses of t	rs were hillip			

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Division of Health Service Regulation							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-859	B. WING_		R 07/22/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP GODE			
DESTINY	FAMILY CARE HOM	E 2 1238 FAIR CARY, NO	LANE ROAL 27511	<b>D</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 COMPLETE		
∨ 367	incidents that occur (6) a statement occur been no reportable incidents have occur meet any of the crit (a) and (d) of this F through (4) of this F	number of level II and level III med; and ent indicating that there have incidents whenever no urred during the quarter that teria as set forth in Paragraphs (1) Paragraph.	V 367				
	Based on record refailed to report level Response Improve the Local Manager Organization (LME becoming aware of audited clients (#1) #6). The findings a Review on 6/19/24 - No IRIS report level II incidents: - 4/10/24: Client - 6/6/24: FC #6 v A. Review on 6/18/revealed: - Admitted 12/1/ - Diagnoses of In Disability (IDD), Art Hyperlipemia & Co	of the IRIS system revealed: submitted for the following #1's hip fracture was committed involuntarily 24 of client #1's record					

		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			
		MHL092-859	B. WING		07/22/2024
			ADDRESS, CITY, S	STATE, ZIP CODE	
	PROVIDER OR SUPPLIER	1238 F	AIRLANE ROA		1
DESTINY	FAMILY CARE HOW	E 2 CARY,	NC 27511		CORRECTION (X5)
(X4) ID PREFIX TAG	CONTRACTOR OF THE STATE OF THE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE DATE
V 367	Continued From p	age 20	V 367		
	admission record  - "Overnight sho unwitnessed fall."	dated 4/10/24 revealed: e (client #1) had an She was found on the floor. S ip pain. X-rays in ER n) show a right femoral neck	i		
	unsuccessful bec hearing and could asked.	ew on 6/18/24 with client #1 vause client #1 was hard of anot comprehend the questic	ons		
	- Admitted 6/5/	9/24 of FC #6's record reveal '24 and discharged 6/6/24 ' Posttraumatic Stress Disord ession Disorder & Asthma	1		
	revealed:  - An incident relicensee: "Ms. [fthat [FC #6] was back. I (Administrate) asked her to give mate. She becare yellingI reminer (ineligible) again incident that hap boyfriend. She generalled 911"	eport dated 6/6/24 written by C #6]'s room mate complain using her phone and wanted rator) went back to her room the phone back to her room ne very upset and started and her using the phone due to pened between her and her ot very upset and jumped fro rged towards me aggressive ape and she tried to hit me. I	ed it and od o an m ly. I		
	revealed: - "This report Commitment Se	24 of a police report dated 6, is in regards to an Involuntal ervice at 1238 Fairlane former Client (FC) #6) was luntarily (IVC'd) at [local hosp	ту		

Division	of Health Service Re	egulation				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL092-859	B. WING	****	07/22/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AN	DRESS COV	STATE, ZIP CODE		
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DESTIN	FAMILY CARE HOM	E 2 CARY, NO			· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DRE COMPLETE	
V 367	Continued From pa	ge 21	V 367			
	Interview on 6/20/2	4 FC #6 reported:				
	<ul> <li>Had an altercal</li> </ul>	ion with the Administrator on		,		
	6/6/24		,	,		
	<ul> <li>I ne Administratives IVC'd</li> </ul>	tor called the police and she		• .		
	was iv C u					
	Interviews on 6/18/2	24 and 6/20/24 the Qualified				
	Professional (QP) r					
	•	le for ensuring IRIS reports				
	.were completed  The Administra	for stated that she completed			,	
		dient #1's fractured hip, but				
		-up" to ensure the IRIS report				
	was completed					
		of the incident that occurred	ì			
	between the Licens	ee and ru #o				
	Interviews on 6/18/2	24 & 7/22/24 the Administrator				
	reported:	the first section and the section is a second section to the section of the secti			'	
	reports were compl	sponsible for ensuring IRIS				
		he QP didn't submit an IRIS				
	for client #1's hip fra			V 726 - Footier Court		
		have completed an IRIS		V 736 – Facility Grounds and Maintenance. The facility		
	report for client #1's					
	- The QP was un FC #6	aware of the incident involving		administrator has started the p of making repairs and paintin	rocess	
		P and LME/MC O of the		specific areas in the group hor	5	
		C #6 "skipped" her memory		Going forward the administra	ne.	
				complete monthly inspections	Or Will	
V 736	27G .0303(c) Facilit	ly and Grounds Maintenance	V 736	home and will make necessary	arux: ,	
		THE STATE OF THE S		repairs or modifications within		
	10A NCAC 27G .03 EXTERIOR REQUI	03 LOCATION AND		timely manner. Additionally, t	ha np	
		its grounds shall be		will inspect at least quarterly a	nd I	
		e, clean, attractive and orderly		advise the administrator that re	naîre	
	manner and shall be	e kept free from offensive		are needed. This will be monit	oned .	
	odor.		,	by QP at least quarterly.		
		j		-		

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Division	of Health Service Re	egulation			1 01 (41) 11 1 1 1 1 1 1 1
AND PLAN OF CORRECTION INCIDENTIFICATION ALLIMPED		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
MNID PILMN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL092-859	B. WING		R 07/22/2024
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET A			STATE, ZIP CODE	
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DESTIN	Y FAMILY CARE HOM	CARY, NO	27511		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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 COMPLETE
V 736	Continued From pa	ge 22	V 736		***************************************
	This Rule is not me Based on observati	et as evidenced by: ion and interview, the facility I in a safe, clean and attractive			
	10:10am revealed:  - Ceiling around stain the approxima peeling off in multip  - The hallway ba stains around the b  - The trim around away from the wall  - The paint behind an area approximate with peeling and but  - The wood on the exposing the latch of the ceiling in ceiling in ceiling covering half  - The double slid	throom had dime sized black athtub sealant di the bathtub was coming and had been taped and the hallway bathroom door cimately 10 inches by 6 inches bbling paint he front door was chipped, of the doorknob lient #5's bathroom had black for the ceiling ling closet doors in client #2 room was off the track and			
	Interview on 6/18/2	hallway was rusted and dirty 24 the Qualified Professional			
	reported: - The Licensee w the facility	vas responsible for repairs to			
	<ul> <li>Planned to have completed by next r</li> </ul>	the repairs completed to "pass			
		been cited 6 times since the 1/22 and must be corrected			

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	NT OF DEFICIENCIES FOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		CARY, N	27511	······································	
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