STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL0411264		B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
DESTINY	CARE LIVING	4707 WE	STWOOD ROAD			
DESTINI	CARE LIVING	GREENS	SBORO, NC 27410			
(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 APPROPR DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2025. Deficiencies we					
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.					
	This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 2 current clients.					
V 290	27G .5602 Supervised	Living - Staff	V 290			
	10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the					
	following client-staff rat child or adolescent clie	tios when more than one nt is present:		RECEIVED		
	(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer miner.			AUG 1 2 2025		
	of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or			DHSR-MH Licensure Sect		

TITLE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED	
		MHL0411264	B. WING		08/	01/2025
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
DESTINY	CARE LIVING	4707 WES	TWOOD ROA	D		
DESTINI	CARE LIVING	GREENSE	BORO, NC 274	410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	OF PROVIDER OR SUPPLIER TINY CARE LIVING SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		V 290	QP and Care Mara will schedule a mee to cooldinat for The rember to have a evaluation to deke If having unsuperul time is appropriate and if so, how Mu	Mari	
	Review on 7/31/25 of a	7/30/25 incident report for				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D. MINIO			
	MHL0411264 B. WING			08/01/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
DESTINY	CARE LIVING		STWOOD ROAD SBORO, NC 27410			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 290		2	V 290			
	two friends without moto the facility. -She contacted Staff # facility. Review on 7/31/25 of geographical location revealed: -An outside temperature Fahrenheit with a heard degrees Fahrenheit. Interview on 7/31/25 where she had been living a monthShe had been living a monthShe lived on her own university and prior to to the previous day (money on lunch for he in the community and for a rideshare back to she called Staff #1 to facilityShe could stay without and in the communityShe did not know abowho took her out into the days a week"If there's an emergent by myself, I will go back door or go in the bathre-She had her own phoremergency. "I would care	while she attended a local her admission. 7/30/25), she spent her reself and two friends while had no money left to pay the facility. be transported back to the t a staff while at the facility ut any female individual he community a couple of cy and I'm here (at facility) k to my room and close the bom or my closet."				
	with the Local Manage Organization revealed:	ment Entity/Managed Care				

Division	of Health Service Regu	lation			FO	RM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411264		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
DESTINY	CARE LIVING		STWOOD ROAD			
			SBORO, NC 27410			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
	was determined by CI-She agreed Client #1 needed to be reasses Interview on 7/31/25 v -She was the AFL Pro-Client #1 was her owiden and the properties of the provious day (7/30/25) wanted to be at the pro-Client #1 met with 2 from the with her money, and we circled area on the graden area on the graden and the facility, Client #1 set the university campus specific locationStaff #1 called an indiversity to help location and the provious day (7/30/25) wanted to be at the pro-Client #1 called an indiversity client #1 set the university campus specific locationStaff #1 called an indiversity to help location and the provided in the communication of the communication of the communication of the provided set of the communication of th	ient #1 and her mother. 's unsupervised time sed. with Staff #1 revealed: vider. In guardian. It me staff notified her that of her day program on the obecause she no longer orgram. It is it is to ask for a ride back to said she was "in a circle" on but could not provide a vidual familiar with the e Client #1. If an assessment for ween 4-6 hours a day, she should be left alone at the unity because Client #1's re her safety. It is team would be the facility when the staff was not oresent at the facility when the facility when the staff was not the staff was not the staff was not the staff was not the staff was mould be staff was not the staff was not th	V 290			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	25 25	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411264	B. WING		08/0	1/2025
17 (0.00007) (0.00004) (0.00004) (1.00004)	ROVIDER OR SUPPLIER CARE LIVING	4707 WE	DDRESS, CITY, ST	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	Continued From page 27G .0304(a) Privacy	4	V 742 V 742			
	EQUIPMENT (a) Privacy: Facilities s constructed in a mann privacy while bathing, facilities.	er that will provide clients dressing or using toilet		The Member will	,	
	failed to provide client using the toilet facilitie	and interview, the facility privacy while bathing and s. The findings are:		no longer be ask to use the bathroom	wed	
	12:54 pm-1:30 pm rev -A staff bathroom was bedroomA shared client bathro	adjacent to the staff's om which required Client ent #1's bedroom to access		in the other Mem room and will us the main buth room in the house	DeD se	
		ient #2 shared a bathroom. through her bedroom to get sleep when Client #2		III THE NULL		
		n, me and the other girl. I use the bathroom and I try				
	Interview on 8/1/25 wit -She could allow Client bathroom for toileting a privacy.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED			
		MHL0411264	B. WING		08/0	1/2025		
DESTINY CARE LIVING 4707 WEST			STWOOD ROA	DRESS, CITY, STATE, ZIP CODE TWOOD ROAD ORO, NC 27410				
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	EQUIPMENT (b) Safety: Each facilic constructed and equipensures the physical svisitors. (4) In areas of the exposed to hot water, water shall be maintain degrees Fahrenheit. This Rule is not met a Based on observation where clients were expfacility failed to ensure maintained between 10 Fahrenheit. The finding Observation on 7/31/25 pm-1:30 pm reverthe sink water temperabathroom was 126 degrather of the tub water temperabathroom was 124 degrather on 7/31/25 will also showers and it hot. Not hot enough to Interview on 7/31/25 will review on 7/31	ty shall be designed, ped in a manner that safety of clients, staff and the facility where clients are the temperature of the ned between 100-116. Is evidenced by: and interview, the areas posed to hot water, the the water temperature was 20-116 degrees gs are: To of the facility between ealed: arture in the shared client grees Fahrenheit. If Client #2 revealed: s nice and hot but not too burn me." Ith Staff #1 revealed: today (7/31/25) about	V 752	The Program Director Contacted the la load to have the la water Heater Serie Program Director Water Check water temps dury and document. Of will ensure that temps are check daily to ensure Jasety	viced C			

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