STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411264	A. BUILDING: ______ B. WING ______	C **10/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY CARE LIVING	**4707 WESTWOOD ROAD** **GREENSBORO, NC 27410**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on October 3, 2025. The complaint was substantiated (intake #NC00233615). Deficiencies were cited. 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 1. The survey sample consisted of an audit of 1 former client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118		

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drug.
(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to administer a prescribed medication on the written order of a person authorized to prescribe drugs. The findings are:

Reviews on 10/2/25 and 10/3/25 of Former Client (FC#1)'s record revealed:
-Admission date of 6/16/25.
-Discharge Date of 11/9/25; however, FC#1 left the facility on 9/11/25.
-Diagnoses of Moderate Intellectual Developmental Disability (IDD), Down's Syndrome, and Hearing Impairment.
-9/5/25, physician ordered Doxycycline Hyclate (Cellulitis of head) 100 milligrams, 1 capsule 2 times daily for 7 days.

Review on 10/2/25 of two text messages between staff of the facility's management company and the AFL Provider revealed:
-9/10/25 at 8:56 am, a text from a staff at the facility's management company to the Alternative Family Living (AFL) Provider revealed FC#1's medicine was at the management company's office.
-9/11/25 at 2:28 pm, a text message from the AFL Provider to a staff at the facility's management

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office revealed the AFL Provider's request to have a staff from the management company "give the medicine" to another management company staff member for FC#1.

Review on 10/3/25 of FC#1's September 2025 MAR revealed:
-Doxycycline Hyclate administered to FC#1 starting on 9/11/25 at the 8 pm dosage time.

Interview on 10/2/25 with FC#1's mother revealed:
-FC #1 had a hearing aid which was attached to a port on her head.
-On 9/5/25, during the evening (pm) hours, FC#1 was taken to the Emergency Room (ER) by Staff #2 to have the area of her head port evaluated because the area looked "infected" and "was swollen."
-FC#1 was prescribed Doxycycline, an antibiotic on 9/5/25 at the ER.
-The Doxycycline was delivered to the facility's management office on 9/8/25 and then delivered to the facility on 9/11/25.
-She was concerned because FC#1 did not receive her antibiotic medication for "almost a week."
-She removed FC#1 from the facility on 9/11/25.
-FC#1 was seen by her Ear, Nose and Throat (ENT) physician on 9/15/25 and 9/26/25.
-On 9/26/25, FC#1 was prescribed another round of antibiotic by her ENT physician, and the affected area was "looking good."

Interview on 10/2/25 with Staff #1 revealed:
-She was not aware FC#1 had been taken to the ER and prescribed an antibiotic until 9/5/25 when the medication was delivered to the facility around 6 pm by a staff from the facility's management company and her telephone call with FC#1's

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V 118	Continued From page 3 mother. Interview on 10/3/25 with Staff #2 revealed: -She worked as a Direct Support Staff on weekends from Friday at 3 pm until Sunday morning (am) or Monday at 9 am. -She was "on-call" for the facility during the week of 9/8/25 due to the AFL Provider having gone on vacation. -She observed on 9/5/25 when she came into work that the area on FC#1's head where the hearing aid attached was swollen and looked infected. -9/5/25, she notified a nurse with the facility's management company and the AFL Provider about the condition of FC#1's head site and was instructed to take FC#1 to the ER to be evaluated. -She took FC#1 to the ER where she was medically evaluated, administered a dose of Doxycycline and was prescribed Doxycycline for "possible infection." -The prescription for the Doxycycline was called into the pharmacy from the ER. -She was not aware the Doxycycline had been delivered to the facility's management company on 9/8/25 because no one had contacted her to pick the medication up. -She became aware the Doxycycline was delivered to the facility on 9/11/25 when Staff #1 communicated with her about FC#1's mother's telephone call. -"I did not receive a telephone call from [the management office] that [FC#1]'s medicine was in. If I had, I would have picked it up." Interviews on 10/2/25 and 10/3/25 with the AFL provider revealed: -She left Staff #2 in charge of the facility while she was on vacation from 9/5/25 through 9/13/25.	V 118		

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-She and a nurse from the facility's management company gave instructions to Staff #2 for FC#1 to be taken to the ER due to "some swelling" near her head port and "to ensure there was no infection."
-"The doctor at the ED (Emergency Department) said there was no infection but prescribed an ointment to put on her (FC#1's) head to prevent infection."
-FC#1's medication was delivered to the facility's management office on 9/8/25 and delivered to the facility on 9/11/25 for Staff #1 to administer.
-"Usually I'm at the [management company] office and told when medicine comes in. I received a text from [management company] on Wednesday (9/10/25) the medicine was there."
-"The [management company] knew I had 2 staff (Staff #1 and #2) looking after the clients (FC#1 and Client #2), including the Qualified Professional. It (FC#1's medicine) got overlooked and the medicine was delivered out here (to the facility) on Thursday (9/11/25)."

Interview on 10/3/25 with the Qualified Professional revealed:
-The pharmacy used by the facility's management company delivered client medications to the management company's office with the facility staff's responsibility to pick the medications up for clients.
-If a medication was prescribed after the management company's normal business hours and the medication cannot wait to be administered to a client, a "special request" can be made from facility staff to the pharmacy to have the medication delivered the same day.
-"I don't know if the staff (Staff #2) knew this at the time."
-" [FC#1]'s medicine should have been picked up before Thursday (9/11/25)."

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V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be 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 visits outside the facility. Reports shall be submitted at least 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 safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate services with a client and the client's family to ensure continuity of medical	V 291		

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care. The findings are:

Review on 10/2/25 of Former Client (FC#1)'s record revealed:
-Admission date of 6/16/25.
-Diagnoses of Moderate Intellectual Developmental Disability (IDD), Down's Syndrome, and Hearing Impairment.

Review on 10/2/25 of FC#1's hospital emergency department after-visit summary revealed:
-The after-visit summary dated 9/5/25 included written instructions for FC#1's Ear, Nose and Throat (ENT) doctor to be called "first thing Monday morning for a follow-up appointment..."

Interview on 10/2/25 with FC#1's mother revealed:
-She did not know FC#1 needed a follow-up appointment with an ENT until she saw the instructions on FC#1's hospital after-visit summary when she picked FC#1 at the facility on 9/11/25.
-FC#1 was seen by her ENT physician the following Monday, 9/15/25.

Interview on 10/3/25 with Staff #2 revealed:
-She was "on-call" for the facility during the week of 9/8/25 due to the Alternative Family Living (AFL) Provider having gone on vacation.
-Being "on-call" meant if any issues came up, she was to be notified.
-She sent FC#1's hospital after-visit summary in a text to the AFL Provider after FC#1 was discharged from the emergency department.
-She was not asked by the AFL Provider to text FC#1's mother the after-care hospital visit summary.
-"I did not send the after-visit summary to Mom."

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V 291	Continued From page 7 Interview on 10/3/25 with the AFL Provider revealed: -" I didn't see it (FC#1's after-visit hospital summary) until I got back from vacation." -" ... [Staff #2] texted it to me but I didn't review it. I was on vacation." -"I left [Staff #2] to act in my place while I was on vacation." -"It was just a miscommunication that [FC#1]'s mother was not informed she (FC#1) needed to follow-up with the ENT." -" ...Mom should have been notified to contact [FC#1]'s ENT so an appointment could have been scheduled that week ."	V 291		