STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11	5. G5.41.261.61.	is Elitti is in it is	A. BUILDING: _	A. BUILDING:		
		MHL041-857	B. WING		R 06/27/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRESH START HOME FOR CHILDREN			RYHILL ROAD ORO, NC 2740	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ΓE
V 000	INITIAL COMMENTS		V 000			
	on 6/27/18. Deficiend	d for the following service 27G .1700 Residential				
V 118	V 118 27G .0209 (C) Medication Requirements		V 118			
	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 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation					

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

(X6) DATE TITLE

DIVISION	of Health Service Regu	liation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
	MUU 044 057				R	
		MHL041-857	B. WING		06/2	7/2018
NAME OF B	DOMBED OF CHIPPLIED	OTDEET AD	DDEGG OITY OTA	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE		
FRESH ST	TART HOME FOR CHILD	REN 1929 MUF	RYHILL ROAD			
I INLOIT O	TART TIOME TOR OTHER	GREENSI	BORO, NC 2740	03		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	≀IATE	DATE
				DEFICIENCY)		
V 118	Continued From page	- 1	V 118			
V 110	Continued From page	5 1	110			
	with a physician.					
	, , , , , , ,					
	This Dule is not need	an adding and how				
	This Rule is not met	_				
		ews, observations and				
	interviews, the facility					
		lications was documented				
	immediately following	administration and				
	medications were adı	ministered on time affecting				
	2 of 2 current clients	(#1 & #2). The findings are:				
		,				
	Review on 6/26/18 of	client #1's record revealed:				
	- Admission date of 6					
		Depressive Disorder,				
		th Psychotic Features,				
		s Disorder, Unspecified,				
		•				
		der, Depressive Type				
	- Age: 18	1.1.1.4/07/00 ()				
	- Physician's orders,					
	following medications					
	_	g (milligrams), one by mouth				
	every morning (QAM)					
	_	, one by mouth QAM:				
	7:00AM;					
	- Clozapine, 125	mg, two by mouth QAM:				
	7:00AM;					
	 Sertraline HCL, 	, 50 mg one by mouth QAM:				
	7:00AM;					
	•	mg, one by mouth twice				
	daily (BID): 7:00AM a	-				
	, ,	Spray, 50 mcg (micrograms),				
	2 puffs QAM in each					
	_ pano & will in caon					
	Davious on 6/26/19 of	client #2's record revealed:				
	- Admission date: 3/1					
		t Disorder, Adolescent				
	Onset Type; Post Tra	umatic- Stress Disorder;				

Division of Health Service Regulation

STATE FORM 6899 OC7P11 If continuation sheet 2 of 9

Division C	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
				A. Bollbino.		
			B. WING		F	
		MHL041-857	B. WING		06/2	7/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE. ZIP CODE		
TO UNIC OT TH	TO VIDER OR OUT FEET		, ,	, 2.11 0002		
FRESH ST	TART HOME FOR CHILDI	REN	RRYHILL ROAD			
		GREENSI	BORO, NC 2740	03		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				22.13.2.13.7		<u> </u>
V 118	Continued From page	e 2	V 118			ı
						ı
	Cannabis Use Disord					ı
	Substance Use Disor	der, Moderate; Major				ı
	Depressive Disorder,	Moderate, Recurrent;				ı
	- Age: 15					ı
		or the following medications:				ı
	•	vdrochloride 25 mg, 1 tablet				ı .
	QHS, dated 5/22/201					ı .
	•	0.05% ointment, apply to				ı .
		e) BID, dated 5/22/2018;				ı .
	,	opram) 10 mg, 1 tablet QD,				ı .
	. ,	opiani) to mg, i tablet QD,				ı .
	dated	amplita affected area				ı
		eam, apply to affected area				ı .
	BID, dated 5/22/18;					ı
		clate 100 mg, 1 tablet BID,				ı
	dated 5/22/18;					ı
	•	0 mg, 3 tablets three times a				ı
	day, dated 3/9/18.					ı
	r					ı
	Review on 6/26/2018	of client #2's MARs date				ı
	4/1/18 to 6/26/18 reve	ealed:				ı
	- No documentation of	of administration of the				ı
	following:					ı
	- Amitriptyline at	7:00AM on May 31;				ı
		at 7:00AM on June 24;				1
		eam at 7:00PM on May 19,				ı
	21 & 24;	zam at 1.001 m on may 10,				ı
		clate at 7:00AM on June 24;				ı
	and	ciate at 1.00AW on build 24,				1
		7:00PM on June 24.				ı
	- Gabapeniin at <i>i</i>	7.00FW 011 Julie 24.				1
	Observation at appro	ximately 8:45AM on 6/26/18				1
	revealed:	XIIIIately 6.45Alvi on 6/26/16				1
		asional (OD) consulted alight				ı
		ssional (QP) consulted client				ı
		dministered client #1's				ı
	7:00AM medications					ı
		essional (AP) consulted				ı
		then administered client #2's				1
	7:00AM medications	to her.				ı
			1 '			

Interview on 6/27/18 with client #1 revealed:

STATE FORM 6899 OC7P11 If continuation sheet 3 of 9

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		MUI 044 957	B. WING		l l	R (27/2048	
NAME OF D		MHL041-857			106/	27/2018	
	ROVIDER OR SUPPLIER	1929 MUF	DRESS, CITY, STA RRYHILL ROAD	IE, ZIP GODE			
FRESH ST	TART HOME FOR CHILD	REN	BORO, NC 2740	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	e 3	V 118				
	-Took prescribed med and 7:00PM -Medications during the year were administer 7:00AM and 8:00AM -During the summer radministered by facilitinStated medications of were administered. "a Interview on 6/27/18 -Recently assumed the Part of her role as the medicationsThe prescribed medication administered between during the school years. The 7:00AM medications.	the mornings of the school ed by facility staff between months medications were ty staff later due to "sleeping during the summer months round 9AM" with the AP revealed: ne role of the AP e AP was to administered facations for 7:00AM were n 6:00AM and 7:00AM					
	-The morning medical be administered between a one hou staff off when you all were kind of flustered and a control of the clical	to administer the 7:00AM ents wed to sleep in during the their 7:00AM medications ter in the morning. with the Owner revealed: ew facility staff en nervous because you					

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R
		MHL041-857	B. WING		06/27/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH START HOME FOR CHILDREN			RYHILL ROAD ORO, NC 2740	13	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
V 118	Continued From page	2 4	V 118		
	months -Administered their m morning -Would discuss with the	he pharmacist and the adjusting the morning times			
V 120	27G .0209 (E) Medica	ation Requirements	V 120		
	and 86 degrees Fahre (B) in a refrigerator, if degrees and 46 degre refrigerator is used fo shall be kept in a sep- or container; (C) separately for each (D) separately for ext (E) in a secure manne for a client to self-med (2) Each facility that in controlled substances registered under the N	le: all be stored: ed cabinet in a clean, d room between 59 degrees enheit; required, between 36 ees Fahrenheit. If the r food items, medications arate, locked compartment ch client; ernal and internal use; er if approved by a physician dicate. maintains stocks of a shall be currently North Carolina Controlled 90, Article 5, including any			
	interviews, the facility	ews, observations, and failed to store internal and separately affecting 1 of 2			

Division of Health Service Regulation

STATE FORM 6899 OC7P11 If continuation sheet 5 of 9

Division	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D WING		R
		MHL041-857	B. WING		06/27/2018
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZID CODE	
NAIVIE OF P	ROVIDER OR SUPPLIER			IE, ZIP CODE	
FRESH ST	TART HOME FOR CHILD	REN 1929 MU	RRYHILL ROAD		
i KLOII O	TART HOME FOR OHIED	GREENS	BORO, NC 2740	13	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
V/ 400	0 " 15	_	V/ 400		
V 120	Continued From page	e 5	V 120		
	Daviow on 6/26/19 of	client #2's record revealed:			
	- Admission date: 3/1				
	_	t Disorder, Adolescent			
		umatic- Stress Disorder;			
	Cannabis Use Disord				
	Substance Use Disor	der, Moderate; Major			
	Depressive Disorder,	Moderate, Recurrent;			
	- Age: 15				
	_	or the following external			
	medications:	C			
		0.05% ointment, apply to			
		e) BID, dated 5/22/2018;			
	,	eam, apply to affected area			
		am, apply to affected area			
	BID, dated 5/22/18;				
	- Physicians orders fo	or 6 other internal			
	medications.				
	Observation at appro	ximately 9:20AM on 6/26/18			
	of client #2's medicat	ions revealed:			
	- 2 tubes of alcometa	sone ointment and 1 tube of			
	Azelex cream were st	tored in the same plastic box			
	with client #2's interna				
		ernal mediations were not			
	separated.				
	Interview on 6/26/18	with the Qualified			
	Professional revealed				
		ations were usually stored in			
	_	er to keep them separated			
	from internal medicat				
	-	ave taken the zip-lock bag			
	out of the medication	box.			
	Interview on 6/27/18	with the Owner/Director			
	revealed:				
	- Internal and externa	Il medications were			
		rated by placing the external			
	medications in zip-loc				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
					R
		MHL041-857	B. WING		06/27/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
FRESH ST	ART HOME FOR CHILD	REN	RRYHILL ROAD BORO, NC 27403	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 COMPLETE
V 736	Continued From page	e 6	V 736		
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736		
		EMENTS			
		ns and interviews, the staff facility in a safe, clean and			
	6/27/18 of the facility - Bedroom #2's door when closed, was diff potential impediment event of an emergence - The carpet in bedroot scattered throughout approximately 2 inche - An electrical outlet re missing in bedroom # accessible to a shock - The doorknob to bed	was difficult to close, and ficult to open creating a to speedy egress in the cy; om #2 had multiple stains the room and a hole as in diameter near the door; ecceptacle cover was 3, leaving the wiring easily hazard; droom #4 was hanging tentially make it difficult to			
	-The bedroom door had caused it to stick. Interview on 6/26/18 v	with client #1 revealed: ad been hard to open which with client #2 revealed: of any issues with the facility			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING: COM	
					R
		MHL041-857	B. WING		06/27/2018
					00/21/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
FRESH ST	TART HOME FOR CHILD	REN 1929 MUR	RYHILL ROAD		
		GREENSE	3ORO, NC 2740	03	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 736	Continued From page	e 7	V 736		
	-Was aware one of the would stick at times -Was not aware there a client's bedroom -"There's a hole in the when that happened. Interview on 6/27/18 Professional revealed -Had observed a hole client's bedroom -Had observed the bedroom did not shut proit difficult to open.	with the Associate d: e in the carpet in one of the edroom door to a client's perly and would get stuck so g the bedroom door and eed of repairs			
	O/D revealed: -Observed the carpet -"That (the hole in the months ago" -Planned to pull up th "wooden planks" -When asked about the	d: any repairs, the was contacted erview on 6/27/18 with the			
	put some WD-40 on i (removed an over the -Stated which ever cli	t. It might even be this			

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-"Look right here (pointed to the hinge on the

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		MHL041-857	B. WING			R 27/2018
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00	
FRESH ST	TART HOME FOR CHILDI	₹FN	RYHILL ROAD BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	door). I will tell our ma	e 8 aintenance man to repair the d balance it out so it won't	V 736			

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