F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SI	JRVEY
				COMPLE	
			And the same of th	1	
	MHL041-857	B. WING		R	7/2040
OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	5 7/B CODE	1 06/2/	//2018
A DT 1/01/15 TO 5		JRRYHILL ROAD	E, AF CODE		
ART HOME FOR CHILD	/E/A	SBORO, NC 27403			
SUMMARY STA	ATEMENT OF DEFICIENCIES	1 1			
(EACH DEFICIENCY REGULATORY OR I	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BF	(X5) COMPLE
	SO IDENTI TING INFORMATION)	TAG		IATE	DATE
INITIAL COMMENTS			DEFICIENCY)		
INITIAL COMMENTS		V 000		44	
An annual and follows	In clinion was commisted				
on 6/27/18. Deficienci	ies were cited	- Transaction			
Jan 10. Denoiche	NO WOLE CITED.				
This facility is licensed	for the following service	-			
category: 10A NCAC 2	27G .1700 Residential	Laboratory.	DHSR - Mental Health		
	e for Children and				
Adolescents.			AUG 1 4 2018		
70			FIGU I TESTS		
27G .0209 (C) Medicat	tion Requirements	V 118	Lie Cont Continu	1	
104 NCAC 27C 0200	MEDICATION	to the second se	Lic. & Cert. Section		
	MEDICATION			i	
	tration.			į	
1) Prescription or non-	prescription drugs shall			Ì	
nly be administered to	a client on the written				
	prized by law to prescribe	1			
				40	
lients only when outher	e self-administered by				
lient's only when autho	inzed in writing by the	The second secon			
Medications, including	ng injections shall be	To an indicate the second seco			
dministered only by lic	ensed persons, or by	Total Control		1000	
nlicensed persons trail	ned by a registered nurse.			-	
harmacist or other lega	ally qualified person and			1	
rivileged to prepare an	d administer medications.			# # 10	
A Medication Admini	stration Record (MAR) of				
rrent Medications add	b each client must be kept				
corded immediately at	fer administration. The			1	
AR is to include the fo	llowing:	To the second se		1	
) client's name;		Table and the same			
) name, strength, and	quantity of the drug;	The state of the s			
 instructions for admi 	nistering the drug;				
) date and time the dr	ug is administered; and				
) riame or initials of pe	erson administering the	To a second seco			
	adication abandes				
ecks shall be recorded	d and kent with the MAD	A section			
followed up by appoin	ofment or consultation				
AC TOTA 2 IR CONTRACTOR TO THE	(EACH DEFICIENCY REGULATORY OR LE REGULATORY OR LE INITIAL COMMENTS An annual and follow on 6/27/18. Deficience on 6/27/19. Medication administered to reserve of a person authorized of a person authorized on 6/27/19. Medications shall be ients only when authorized only by licents only when authorized on 6/27/19. Medications, including administered only by licents only when authorized to prepare and 10/27/27/27/27/27/27/27/27/27/27/27/27/27/	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 6/27/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential freatment Staff Secure for Children and Adolescents. AND ACAC 27G .0209 MEDICATION REQUIREMENTS COA NCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .0209 MEDICATION REQUIREMENTS COA MCAC 27G .1700 Residential Reviewere cited An annual and follow up survey was completed Coa MCAC 27G .1700 Residential Review Regulation The AC I and The MCAC 27G .1700 Residential REQUIREMENTS COA MCAC 27G .1700 Residential Review Regulation REQUIREMENTS An annual and follow up survey was completed Coa MCAC 27G .1700 Residential Review Regulation The AC I and The MCAC 27G .1700 Residential Review Regulation Review Regulation The AC I and The MCAC 27G .1700 Residential Review Regulation The AC I and The MCAC 27G .1700 Residential REQUIREMENTS The MCAC 27G .1700 Residential The AC I and The MCAC 27G .1700 Residentia	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 6/27/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential freatment Staff Secure for Children and Adolescents. AN ACAC 27G. 0209 MEDICATION RESIDENTIFY IN THE PROPERTY OF TH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 6/27/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential freatment Staff Secure for Children and Adolescents. OA NCAC 27G. 0209 MEDICATION REQUIREMENTS 2) Medication administration: 1) Prescription or non-prescription drugs shall nly be administered to a client on the written dref of a person authorized by law to prescribe rugs. 2) Medications, including injections, shall be diministered only by licensed persons, or by licensed persons trained by a registered nurse, narmacist or other legally qualified person and livileged to prepare and administration. The AR is to include the following: (a) A Medications administration Record (MAR) of drugs administered to each client must be kept irrent. Medications administration Record (MAR) of drugs administered to each client must be kept irrent. Medications administered thall be coorded immediately after administration. The AR is to include the following: (a) client's name; (b) date and time the drug is administerered; and in name or initials of person administering the drug; (c) instructions for administering the drug; (c) instructions for administering the drug; (c) and the drug is administered; and in name or initials of person administering the Mark followed up by appointment or consultation entire Regulation	SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 6/27/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G: 1700 Residential reatment Staff Secure for Children and Modelescents. AN ANDREAM STATE STATE OF CHILDREN STATE OF CONTROL OF STATE OF CONTROL OF STATE OF STATE OF CONTROL OF STATE O

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

99

OC7P11

8-9-18.
If continuation sheet 1 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			1 20125 0			R
		MHL041-857	B. WING		1	27/2018
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE		
FRESH S	TART HOME FOR CHILDS	REN	RYHILL ROAI			
GREENSBORO, NC 27403						T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	1	V 118	33. 31. 495.01173		
	with a physician.					
	This Rule is not met a Based on record revie interviews, the facility administration of medi immediately following medications were adm 2 of 2 current clients (a Review on 6/26/18 of - Admission date of 6/- Diagnoses of Major Diagnoses of Ma	ws, observations and failed to ensure cations was documented administration and ninistered on time affecting #1 & #2). The findings are: client #1's record revealed: 14/17 Depressive Disorder, Psychotic Features, Disorder, Unspecified, er, Depressive Type ated 4/27/28 for the (milligrams), one by mouth 7:00AM, one by mouth QAM: ng, two by mouth QAM: ng, one by mouth twice depray, 50 mcg (micrograms), postril: 7:00AM. lient #2's record revealed: 18 Disorder, Adolescent		27G .0209 (C) Medication Requirements The "new hires" were the staff that did record the medication on the MAR after given the medication to the client. A meeting was held on 6/28/18. During this meeting the QP and AP did of medication protocol and supervision staff. The QP also notified staff that me time would change from 7am to 8am du summer months while the clients were school, to give them an opportunity to slittle longer. This would prevent medicibeing given outside of the allotted medication given outside of the allotted medication period. (one hour before /o after) To prevent further errors the AP observistaff dispensing medication to each clie ensure correct procedure for dispensing recording medication was correct. The AP will do daily medication checks ensure that all medication was given an recorded on the MAR correctly and on the correctly day. The QP will perform weekly audits to the log to ensure accuracy.	a review for all dication uring the out of sleep a ation cation ne hour e each nt, to g and to d	06/28/18

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED				
						3			
		MHL041-857	B. WING			27/2018			
					1 00/2	2772010			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
FRESH ST	TART HOME FOR CHILDS	SEN	RYHILL ROAL						
		GREENSB	ORO, NC 274	103					
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE			
TAG	REGULATORY OR E	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE			
V 118	Continued From page	2	V 118						
	Cannabis Use Disorde	er, Moderate; Other							
	Substance Use Disord	der, Moderate; Major							
	Depressive Disorder,	Moderate, Recurrent;							
	- Age: 15								
		r the following medications:							
		drochloride 25 mg, 1 tablet							
	QHS, dated 5/22/2018					1			
		0.05% ointment, apply to) BID, dated 5/22/2018;							
	recommendation of the property of the second	pram) 10 mg, 1 tablet QD,							
	dated	pramy ro mg, r tablet QD,							
	- Azelex 20% crea	am, apply to affected area				- 1			
	BID, dated 5/22/18;					- 1			
		late 100 mg, 1 tablet BID,							
	dated 5/22/18;								
		mg, 3 tablets three times a							
	day, dated 3/9/18.								
	Review on 6/26/2018 of 4/1/18 to 6/26/18 reverse	of client #2's MARs date							
	- No documentation of								
	following:					1			
		:00AM on May 31;				1			
		t 7:00AM on June 24;							
		am at 7:00PM on May 19,				- 1			
	21 & 24;					1			
		ate at 7:00AM on June 24;				- 1			
	Gabapentin at 7:	00PM on June 24.				1			
	- Gabapelitili at 7:	OUT IN OUT JUILE 24.							
	Observation at approxi	imately 8:45AM on 6/26/18							
	revealed:	,							
	- The Qualified Profess	sional (QP) consulted client				1			
	#1's MAR and then add	ministered client #1's							
	7:00AM medications to								
	- The Associate Profes								
		en administered client #2's							
	7:00AM medications to	ner.							
	Interview on 6/27/18 w	ith client #1 revealed:							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMPLETED
					R
		MHL041-857	B. WING		06/27/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE	
FDFSH S1	TART HOME FOR CHILDS	1929 MUR	RYHILL ROAL	D .	
TRESITO	TAKT HOWE TOK CHIEDI	GREENSE	BORO, NC 274	403	
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 118	Continued From page	3	V 118		
	-Took prescribed med and 7:00PM -Medications during the year were administered 7:00AM and 8:00AM -During the summer in administered by facility in administered between during the role as the medications administered between during the school year administered between during the sch	dications at 7:00AM, 2:00PM the mornings of the school and by facility staff between the months medications were by staff later due to "sleeping thuring the summer months found 9AM" with the AP revealed: a role of the AP a AP was to administered cations for 7:00AM were a 6:00AM and 7:00AM frons, administered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients with the QP revealed: a considered on a tered late due to the clients and a considered on a tered late due to the clients a considered on a tered late due to the clients a considered on a consi	V 118		
	summer months and the	neir 7:00AM medications			
	-Had recently hired ner -"They must have beer guys (two surveyors) w -Medications were usu	rith the Owner revealed: w facility staff n nervous because you			

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		COMPI	LETED	
1						R
		MHL041-857	B. WING		1	27/2018
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST	ATE, ZIP CODE	1 007	2112010
FRESH START HOME FOR CHILDREN 1929 MURRYHILL ROAD						
FRESH S	IART HOWE FOR CHILDS	GREENSBO	ORO, NC 274	103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	4	V 118			
	-Allowed the clients to months -Administered their morning -Would discuss with the	edications later in the ne pharmacist and the adjusting the morning times				
V 120	27G .0209 (E) Medica	tion Requirements	V 120	Medication Requirement (Medication Stor	age)	
	10A NCAC 27G .0209 REQUIREMENTS (e) Medication Storage (1) All medication shall (A) in a securely locke well-lighted, ventilated and 86 degrees Fahre (B) in a refrigerator, if degrees and 46 degre refrigerator is used for shall be kept in a sepa or container; (C) separately for each (D) separately for exte (E) in a secure manne for a client to self-med (2) Each facility that m controlled substances registered under the N	MEDICATION e: I be stored: d cabinet in a clean, room between 59 degrees nheit; required, between 36 es Fahrenheit. If the food items, medications rate, locked compartment n client; rmal and internal use; r if approved by a physician icate. aintains stocks of shall be currently orth Carolina Controlled 20, Article 5, including any		The QP and AP during the staff meeting he 06/28/18 reviewed the storage of medication The QP went over how internal and external medication needs to be stored separately. TQP reminded all staff that the Plastic zip lock in the client's medication container stored the external medication. To prevent further errors the AP observe each staff dispensing medication to each client, to ensure correct procedure for dispensing and recording medication was correct. The AP will do daily medication and med sto container checks to ensure that all medication stored, dispensed and recorded on the MAR correctly The QP will perform weekly audits to the MA and medication storage to ensure accuracy.	nn. I The k bag e ch o I arage on is	06/28/18
		vs, observations, and ailed to store internal and eparately affecting 1 of 2				

PRINTED: 06/28/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R MHL041-857 B. WING _ 06/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1929 MURRYHILL ROAD FRESH START HOME FOR CHILDREN GREENSBORO, NC 27403 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From page 5 V 120 Review on 6/26/18 of client #2's record revealed: - Admission date: 3/18/18 - Diagnoses: Conduct Disorder, Adolescent Onset Type; Post Traumatic- Stress Disorder; Cannabis Use Disorder, Moderate; Other Substance Use Disorder, Moderate: Major Depressive Disorder, Moderate, Recurrent; - Age: 15 - Physicians orders for the following external medications: - Alclometasone 0.05% ointment, apply to affected area (on face) BID, dated 5/22/2018; - Azelex 20% cream, apply to affected area BID, dated 5/22/18; - Physicians orders for 6 other internal medications.

medications in zip-lock bags. Division of Health Service Regulation

revealed:

separated.

Professional revealed:

from internal medications;

out of the medication box.

Observation at approximately 9:20AM on 6/26/18

- 2 tubes of alcometasone ointment and 1 tube of Azelex cream were stored in the same plastic box

- The internal and external mediations were not

- The external medications were usually stored in a zip-lock bag in order to keep them separated

- Facility staff must have taken the zip-lock bag

Interview on 6/27/18 with the Owner/Director

supposed to be separated by placing the external

- Internal and external medications were

of client #2's medications revealed:

with client #2's internal medications:

Interview on 6/26/18 with the Qualified

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				R		
	MHL041-857	B. WING		06/27/2018		
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
FRESH START HOME FOR CHILDREN 1929 MURRYHILL ROAD GREENSBORO, NC 27403						
PREFIX (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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
V 736 Continued From page	6	V 736				
V 736 27G .0303(c) Facility a	nd Grounds Maintenance	V 736	Facility and Ground Maintenance			
10A NCAC 27G .0303 EXTERIOR REQUIRE (c) Each facility and its maintained in a safe, c manner and shall be ke odor.	MENTS grounds shall be lean, attractive and orderly		The door knob on bedroom #4 was repaire. The wall outlet in bedroom #3 installed on On 7/12/2018 the repairs on bedroom #2 v completed. The hinges were replaced and the bedroom closed and open fine. The carpet was replaced in bedroom# 2 are hallway to that room.	06/27/18 vas m door nd the entry		
failed to maintain the fa attractive manner. The Observations at approx 6/27/18 of the facility grade attractive manner. The Observations at approx 6/27/18 of the facility grade at the facility grad	and interviews, the staff acility in a safe, clean and findings are: cimately 12:55AM on rounds revealed: as difficult to close, and ult to open creating a speedy egress in the speedy egress in the in diameter near the door; ceptacle cover was leaving the wiring easily azard; com #4 was hanging ntially make it difficult to sfully closed.		To ensure that all repairs are take care of i matter, The Director pull the following systeplace. The AP is to do daily room and facility check that facility is safe and clean. All minor repairs are to be sent to the office weekly basis. Major repairs are to be reported to the Dire immediately. These procedures were discussed during the manager's meeting held on 07/8/2018 which held by the Director. These procedures were modify and put into 07/16/2018	ems in cks to make e on a ctor he ch were		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL041-857	B. WING			R 27/2018
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE	1 00/	2//2010
FRESH ST	TART HOME FOR CHILD	1929 MUR	RRYHILL ROAD	į.		
TRESTO	TAKT HOME FOR CHIED	GREENS	BORO, NC 274	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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 736	Continued From page	7	V 736			
	-Was aware one of th 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 v Professional revealed -Had observed a hole client's bedroom -Had observed the be room did not shut projit difficult to open.	with the Associate : in the carpet in one of the droom door to a client's perly and would get stuck so g the bedroom door and ed of repairs				
	O/D revealed: -Observed the carpet -"That (the hole in the months ago" -Planned to pull up the "wooden planks"	eny repairs, the was contacted rview on 6/27/18 with the in a client's bedroom carpet) wasn't there a few				
	getting stuck, the O/D put some WD-40 on it (removed an over the -Stated which ever clie the swollen door must	stated "All we have to do it . It might even be this				

Division of Health Service Regulation

OC7P11

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		MHL041-857	B. WING			R 27/2018
-			<u> </u>		1 00/	2772010
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST			
FRESH ST	TART HOME FOR CHILDE	2FN	RYHILL ROAD ORO, NC 274			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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
V 736	Continued From page	8	V 736			
V 736	door). I will tell our ma	sintenance man to repair the distance it out so it won't	V 736			