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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SURPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	**************************************			and an annual resource and the second			
		MHL026-822	B. WING	and the second and th	12/21/2018		
			DRESS, CITY, ST	TATE, ZIP CODE	F 1000 Apr. 11 de		
	7866 ADRIAN DRIVE						
FRESH S	TART RESIDENTIAL		// I E NC 2	024.4			
(X4) ID	FAYETTEVILLE, NC 28314 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE		
∨ 000	INITIAL COMMEN	TS .	V 000				
	An annual survey v 21, 2018. Deficience	vas completed on December cies were cited.					
	category: 10A NCA	sed for the following service AC 27G .5600C Supervised th Developmental Disabilities.					
V 131	G.S. 131E-256 (D2 Verification	2) HCPR - Prior Employment	V 131				
	REGISTRY (d2) Before hiring health care facility	ealth care personnel into a or service, every employer at a shall access the Health Care		·			
	Personnel Registry	y and shall note each incident opropriate business files.					
	Based on record re failed to access the Registry (HCPR) p	net as evidenced by: eview and interview, the facility e Health Care Personnel prior to hire affecting 1 of 1 had been hired within the past 5 The findings are:					
	Review on 12/21/1 -Paraprofessional	8 of Staff #5's record revealed: hired 9/28/18.		DHSR - Mental H	ealth		
	E .	umented 11/24/18. In the HCPR was checked prior		JAN 2 3 2019			
	to her hire.			Lic. & Cert. Sect	ion		
	Staff #5 on 12/20/requesting a return	w Staff #5. Phone call made to 18 at 3:03 pm; message left n call. No call received.					
Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE							
Domontay Munford Director 1/17/2019							
Domontoy Munford Director 1/17/2019							
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Division of Health Service Regulation

STATE FOR	'M		6899	K6MI11	If continua	tion sheet 1 of 3
STATEMENT OF DEFICIENCIES AND PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL026-822	B. WING		12/2	1/2018
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
		7866 ADR	IAN DRIVE			
FRESH S	START RESIDENTIAL		/ILLE NC 1	0024 <i>8</i>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ILLE, NC 2 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETE DATE
V 131	stated: -They changed thei HCPR prior to the s hire a couple of yea -This was because survey that instruc -Prior to the past su the HCPR prior to h -After review of cita 12/15/15 (failure to QP stated she wou	18 the Qualified Professional ir process of checking the start date, rather than prior to ars ago. of a citation during a past ted them change this process. urvey findings, they checked	V 131	Administrative staff will process all personnel files to confirm HCPR da prior to hire date which was previous noted as orientation date in the particle of work. All new employee's HCPR will be or prior to hire and orientation proces will check HCPR immediately followinterview and report findings to D who will place in staff file. QA/QI team will review personnel quarterly or as needed to confirm of required documentation.	ate is ously ast and first day checked ess. QP wing irector	02/18/19 Ongoing Ongoing

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Division	Division of Health Service Regulation					
V 774	27G .0304(d)(7) Mir	nimum Furnishings	V 774			
	EQUIPMENT (d) Indoor space recognize to October 1, 1 minimum square for at that time. Unless Rules, residential fa 1, 1988 shall meet to requirements: (7) Minimum furnish include a separate li	quirements: Facilities licensed 1988 shall satisfy the otage requirements in effect otherwise provided in these acilities licensed after October the following indoor space nings for client bedrooms shall bed, bedding, pillow, bedside for personal belongings for				
	This Bulletin is a second					
	This Rule is not me Based on observati	et as evidenced by: ons and interview, the facility				
		to maintain minimum				
	furnishings for clien	t bedrooms. The findings are:				
	ealth Service Regulation	,		200414		
STATE FOR				K6MI11		tion sheet 2 of 3
	IT OF DEFICIENCIES AND ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '		(X3) DATE SURVEY COMPLETED	
	•		A. BUILDING:			
			B. WING	**************************************		
		MHL026-822			12/2	1/2018
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
		7866 ADR	IAN DRIVE			
FRESH START RESIDENTIAL FACILITY, INC						
			VILLE, NC 2	28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
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Division of Health Service Regulation

	Of Fleath Service Negalation			
V 774	Continued From page 2	V 774	<u>V744</u>	
,	Observations on 12/20/18 at 10:07 am of client bedrooms revealed:	,	Bedside tables have been placed in all bedrooms in the home.	02/18/19
	-The facility had 4 clientsNone of the clients had a bedside table.		Director and QP will review rules and regulations manual and attend trainings as	Ongoing
	Interview on 12/20/18 the Group Home Manager stated:		provided to ensure facility compliance.	
			QA/QI team will continue to meet and work towards ensuring facility is compliance of all rules and regulations for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services manual.	Ongoing
Division of h	l lealth Service Regulation	1	L	<u> </u>

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