

PRINTED: 05/16/2019  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-685</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/24/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEW BEGINNINGS HEALTH CARE PHASE III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3501 NEPTUNE DRIVE RALEIGH, NC 27604</b>
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(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
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V 000	INITIAL COMMENTS  An Annual survey was completed 04-24-19. A deficiency was cited.	V 000		
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V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interview, the facility failed to be maintain as a safe environment. The findings are:  Observation 04-22-19 at approximately 11:30am revealed the smoke detector outsided the first client's bedroom and in the kitchen area chirped throughout the home.  Interview on 04-22-19, clients #1-#4 verified they heard the chirping sound. All clients reported the chirping sound had been heard for a few weeks.	V736	<b>G.S.122C-80 Criminal history Record Check</b> Our agency took immediate action to ensure the quality of all homes. We held a board meeting and reviewed the DHSR deficiencies in its entirety. Different scenarios were discussed and preventative measures/interventions were reviewed and voted on for approval by the Board. We immediately completed an in house audit and had the battery replaced that was causing the chirping sound.		
			Measures put in place to correct the deficient area of practice and how we identified other areas of the facility having the potential to be affected by the same deficient practice and what corrective actions will be taken		
			Measures put in place to prevent the problem from occurring again	Upon learning of the deficiency, our agency placed the below preventative measures in place. We have added to our contract, a weekly check off list to listen for any chirping noise and low battery indicators.	
			Who will monitor the situation to ensure it will not occur again	The Executive Director, Director and our Quality management/Quality Improvement Director, Human Resource Personnel and or a designated qualified staff will continue to monitor the implementation to ensure that the deficiency will not occur again.	
			How often the monitoring will take place	Our agency made sure the above plan happened by implementing the change in the team that actually completes weekly in house audits to ensure the error does not occur again.	
			Dates the corrective action will be completed	The corrective action was completed on 4/24/19	

	Interview on 04-23-19, staff #3 stated the following: -worked third shift 12:00am-8:00am -chirping sound heard throughout the home maybe the alarm system			
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Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Director,*

TITLE

*Gonia Ward*

(X6) DATE

*5/28/19*

STATE FORM

6899

X79J11

If continuation sheet 1 of 2

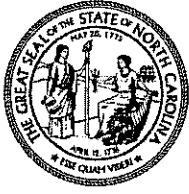
**RECEIVED**

By DHRS-Mental Health Licensure at 1:52 pm, May 31, 2019

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-685</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEW BEGINNINGS HEALTH CARE PHASE III</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3501 NEPTUNE DRIVE RALEIGH, NC 27604</b>		
(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 736	Continued From page 1  Interview between 04-18-19 and 04-24-19 director /qualified professional stated the following: -04-22-19: she thought the smoke detector may need battery replaced. She would have the maintenance replace the battery -04-24-19: the chirping sound may be the alarm system and not the smoke detector	V 736			



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

May 23, 2019

Ms. Sonia Ward, Director  
The Bruson Group, Inc.  
4225 Coldwater Springs Drive  
Raleigh, NC 27616

Re: Annual Survey completed 04-24-19  
New Beginnings Health Care Phase III, 3501 Neptune Drive, Raleigh, NC 27604  
MHL # 092-685  
E-mail Address: ALLMYTEEGOD@AOL.COM

Dear Ms. Ward:

Thank you for the cooperation and courtesy extended during the annual survey completed 04-24-19.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- All tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is 06-24-19.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

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**Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.**

***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

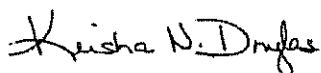
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

05-23-19  
Sonia Ward  
The Bruson Group, Inc.

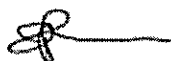
Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski at 919-552-6847.

Sincerely,




Keisha N. Douglas  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section



India Vaughn-Rhodes  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: [qmemail@cardinalinnovations.org](mailto:qmemail@cardinalinnovations.org)  
Leza Wainwright, Director, Trillium Health Resources LME/MCO  
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO

**New Beginnings Health Care Phase III 092-685 Annual 4-24-19****From:** McMickle, Susan R <Susan.McMickle@dhhs.nc.gov>**To:** ALLMYTEEGOD@AOL.COM <ALLMYTEEGOD@AOL.COM>**Cc:** qmemail@cardinalinnovations.org <qmemail@cardinalinnovations.org>; leza.wainwright@trilliumnc.org <leza.wainwright@trilliumnc.org>; Fonda.Gonzales@trilliumnc.org <Fonda.Gonzales@trilliumnc.org>; Pridgen, Pam <Pam.Pridgen@dhhs.nc.gov>; Reeves, Danalouise V <Danalouise.Reeves@dhhs.nc.gov>**Date:** Thu, May 23, 2019 8:28 am [New\\_Beginnings\\_Healt...pdf \(54 KB\)](#) [New\\_Beginnings\\_Healt...pdf \(469 KB\)](#)

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attached the results of the survey completed on 4/24/19 by the MHL&C Section.

The Mental Health Licensure and Certification section is offering a 3-hour session for providers who currently hold a Mental Health License (MHL) for a mental health, developmental disability or substance abuse service. The purpose of this training is to help providers gain knowledge and understanding regarding North Carolina rules & General Statutes, the MHL&C survey process, administrative sanctions and appeal opportunities, and how these rules and processes fit together. The class is free but spaces are limited and registration is required. If you are interested in finding out more, please visit the web page: <http://www.ncdhhs.gov/dhsr/mhlc/training.html>

Thank you,

Susan McMickle  
Administrative Specialist I  
Division of Health Service Regulation, Mental Health Licensure and Certification Section  
NC Department of Health and Human Services

Main Office: 919-855-3795  
Direct Office: 919-855-3963  
Fax: 919-715-8078  
[Susan.McMickle@dhhs.nc.gov](mailto:Susan.McMickle@dhhs.nc.gov)

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1800 Umstead Drive  
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Bruson Group

7417 Knightdale Blvd  
Knightdale, NC 27545  
(O) 919.261.8566  
(F) 919.261.8569

# Fax Coversheet

TO: <u>DHHS</u>	FROM: <u>Sonia Ward</u>
FAX: <u>919-715-8078</u>	PAGES: <u>6</u>
PHONE:	DATE: <u>5/30/19</u>
RE: <u>plan of correction</u>	CC:

NUMBER OF SHEETS INCLUDING FAXED INCLUDING COVER:

COMMENTS:

Have a wonderful day

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