	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COM	SURVEY PLETED	
			A. BUILDING.	A. BUILDING:			
		MHL036-336	B. WING		09/29/2020		
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
RESH NE	W START		NTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE	
V 000	INITIAL COMMENTS	3	V 000				
	A complaint survey was completed on September 29, 2020. The complaint was unsubstantiated (Intake #NC168184). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.						
	sister facility is identi Clients are identified and a numerical iden with only a numerica	ntified in this report. The fied as Sister Facility A. using the letter of the facility tifier. All staff are referred to I identifier. Through multiple ablished that staff were ities.					
	including the exit corr staff continued to be Health Service Regu eventually identified. made to Licensee #1 Professional #1 and Director for a comple staff at the onset of the were made via phone approximately 10:300 licensees on 8/10/20 10:17am. A staff list fax on 8/12/20 after 5 8/13/20. The list reve During survey, it was current and former st reported by either lice These staff were disc	Licensee #2/Executive the list of current and former the survey. The requests e call on 8/10/20 at am and via email to both at 11:22am and 8/11/20 at was eventually received via 5:00pm and was reviewed on ealed "No former staff." a discovered that multiple taff were not voluntarily ensee to the DHSR surveyor. cussed in interviews, but the					
	on the requested list.	members were not identified Email correspondence sent 8/26/20 at 3:32pm and					

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

TITLE

(X6) DATE

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		MHL036-336	B. WING		09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE			
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 000	Continued From page	e 1	V 000				
	they did not know the 8/27/20, DHSR non-of from previous survey Staff #11/Former Clie Former Staff #12 wer was identified as Stat occurred when Licen revealed in an email Staff #6 was on-site a 7/31/20, 8/1/20, and a Department of Social Facility A and that it v the safety plan for Sis Licensee #2/Executiv was only working for training. An additiona identified during exit. Director revealed she needed to be identified	d. The licensees reported e individuals in question. On disclosed documentation s was reviewed. Former ent #A2's Grandmother and re identified. A female staff ff #6. This identification see #2/Executive Director on 9/3/20 at 12:31pm that					
V 108	 (g) Employee trainin provided and, at a mi following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet 	2 PERSONNEL tion shall be documented. g programs shall be nimum, shall consist of the ational orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation	V 108				

Division of Health Service Reg STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
		MHL036-336	B. WING		09	/29/2020		
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE				
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		4) ID SUMMARY STATEMENT OF DEFICIENCIES ID EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLET DATE
V 108	.5602(b) of this Subc member shall be ava times when a client is member shall be train including seizure man to provide cardiopuln trained in the Heimlic techniques such as the the American Heart A equivalence for reliev (i) The governing bo implement policies an reporting, investigatin	ns. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all s present. That staff ned in basic first aid nagement, currently trained nonary resuscitation and ch maneuver or other first aid hose provided by Red Cross, Association or their <i>v</i> ing airway obstruction.	V 108					
	received training to n served affecting 8 of (Licensee #1/Directo Licensee #2/Executiv Professional, Staff #4 and Staff #9) and 2 of (Former Staff #11/ Fo Grandmother and Fo findings are: Review on 8/11/20, 8	record review, and ity failed to ensure staff neet the needs of the clients 10 audited staff members r/Qualified Professional #1, ve Director, Associate 4, Staff #5, Staff #6, Staff #8, of 2 audited former staff ormer Client #2's rmer Staff #12). The						
	Former Client #1's re -Admitted 12/27/19; -Discharged 8/6/20; alth Service Regulation	cord revealed:						

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From pag	e 3	V 108			
	-Diagnosed with Disr Disorder and Attentio Disorder; -11 years old; -Undated Residentia history of sexual abu -Initial Assessment of #1/Director/Qualified 12/26/19 revealed: " ball of trauma. Mom health issues. Mom day. Possible sexua " Review on 8/11/20, 8 Former Client #2's re -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Pos and Attention Deficit -9 years old; -Treatment plan upda Client #2 may have b age of 5 or 6 years of Review on 8/11/20, 8 Former Client #3's re -Admitted 6/12/20; -Discharged 8/4/20;	ruptive Mood Dysregulation on Deficit Hyperactivity I Application revealed a ise; ompleted by the Licensee Professional #1 dated 'From therapist: Walking was a drug attic, mental would set her in the swing all lized behaviors in the past 8/12/20 and 8/18/20 of ecord revealed: at Traumatic Stress Disorder Hyperactivity Disorder; ate 7/11/20 revealed Former been sexually molested at the Id. 8/12/20 and 8/18/20 of ecord revealed:				
	Disorder, Post Traun Oppositional Defiant -13 years old; -Undated Residentia	ntion Deficit Hyperactivity natic Stress Disorder, Disorder, Depression; I Application revealed a appropriate behaviors with "				
	gotten older and freq -Historical informatio 7/16/20 revealed a re	ed behavior as she has juently talks about sex;" n from Treatment Plan dated ecent increase in sexualized ntly talking about sex and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		A. BUILDING:				
		MHL036-336	B. WING		09	0/29/2020
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	W START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID			ID	PROVIDER'S PLAN ((X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
V 108	Continued From pag	e 4	V 108			
	reporting she is having sex with peers. "Client is not able to maintain appropriate boundaries					
		and will 'smell' others.				
		s a great personality trait"				
		/ completed by the Licensee				
		Professional #1 dated sexual assault allegation				
		nt and unsubstantiated;"				
	0	nical Assessment (CCA)				
	addendum complete	· · · ·				
	•	d Professional #2 dated				
	8/17/20 revealed: ".	has no understanding of				
	boundaries and she					
		rubbing on them and				
	hugging without pern	nission"				
	Review on 8/11/20, 8	8/12/20 and 8/18/20 of				
	Former Client #4's re	cord revealed:				
	-Admitted 4/24/20;					
	-Discharged 8/6/20;					
	-Diagnosed with Opp and Unspecified Trai	ositional Defiant Disorder				
	-13 years old;	lina,				
	•	ompleted by the Licensee				
		Professional #1 dated				
		[Former Client #4] was				
	caught kissing her ro	om mate in previous				
	placements;"					
		npleted by the Licensed				
		d Professional #2 dated				
		t has difficulty with sexual				
	•	se/rape, and displays				
		e behaviors and "[Former ual comments to peers and				
	displays sexual gest	•				
		d 8/6/20 revealed Former				
		rged due to being the alleged				
	perpetrator of a sexu					
	involving another pee	-				1

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		-	
		MHL036-336	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From page	e 5	V 108			
	Review on 9/8/20 an #1/Director/Qualified revealed: -Hire date not record -No documentation of sexually aggressive y -No documentation of treatment plans; -Trained himself in th MH/DD/SAS (Mental Disability/Substance 2/8/18, Person Cente Health and Safety da Competency dated 2 Confidentiality dated Management and Pla Review on 9/8/20 of with Division of Healt (DHSR) for the facilit -Licensee #1/Directo was identified on the licensure dated 12/30 issued on 4/10/20. Review on 9/8/20 of with DHSR for Sister -Licensee #1/Directo was identified on the and on the license is Review on 9/8/20 an #2/Executive Directo -Hire date of 8/1/18; -No documentation of sexually aggressive y	d 9/9/20 of Licensee Professional #1's record ed; f training in human sexuality, youth, or sexual trauma; f training in client specific ef following topics: Health/Developmental Abuse Services) dated ered Thinking dated 2/7/18, ted 2/9/18, Cultural /10/18, Rights and 2/11/18, and Crisis anning dated 2/10/18. Initial Licensure Application th Service Regulation y revealed: r/Qualified Professional #1 application for initial D/19 and on the license Initial Licensure Application Facility A revealed: r/Qualified Professional #1 application dated 5/14/18 sued on 6/13/18. d 9/9/20 of Licensee				

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	MUL 000 000	B. WING			
				09	/29/2020
EW START	GASTO	NIA, NC 28056			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
Continued From page	e 6	V 108			
sexually aggressive y	youth, or sexual trauma;				
treatment plans. Review on 9/9/20 of 3 -Hire date of 7/1/20; -No documentation of sexually aggressive y	Staff #4's record revealed: f training in human sexuality, youth, or sexual trauma;				
Review on 9/9/20 wit -Hire date of 6/24/20 -No documentation o sexually aggressive	; f training in human sexuality, youth, or sexual trauma;				
#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record again on 9/8/20 at 1:3	successful as no records for review. Requests for the nt to Licensee Professional #1 and /e Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be				
revealed: -Hire date of 6/5/20; -No documentation o sexually aggressive y	f training in human sexuality, youth, or sexual trauma;				
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag record revealed: -Hire date of 7/1/19; -No documentation of sexually aggressive y -No documentation of treatment plans. Review on 9/9/20 of -Hire date of 7/1/20; -No documentation of sexually aggressive y -No documentation of treatment plans. Review on 9/9/20 witt -Hire date of 6/24/20 -No documentation of sexually aggressive y -No documentation of treatment plans. Review on 9/9/20 witt -Hire date of 6/24/20 -No documentation of treatment plans. Attempted review on #6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record again on 9/8/20 at 1: sent via secured and Review on 9/8/20 and revealed: -Hire date of 6/5/20; -No documentation of sexually aggressive y -No documentation of sexually aggressive y	IDENTIFICATION NUMBER: MHL036-336 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 record revealed: -Hire date of 7/1/19; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. Review on 9/9/20 of Staff #4's record revealed: -Hire date of 7/1/20; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. Attempted review on 9/4/20 and 9/8/20 of Staff #6's records was unsuccessful as no records were made available for review. Requests for the staff records was unsuccessful as no records were made available for review. Requests for the staff records was unsuccessful as no records were made available for review. Requests to the sent via secured and encrypted email. Review on 9/8/20 and 9/9/20 of S	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL036-336 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 6 V 108 record revealed: -Hire date of 7/1/19; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. Review on 9/9/20 of Staff #4's record revealed: -Hire date of 7/1/20; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. Review on 9/9/20 with Staff #5 revealed: -Hire date of 6/24/20; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. Review on 9/9/20 with Staff #5 revealed: -Hire date of 6/24/20; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. Attempted review on 9/4/20 and 9/8/20 of Staff #6's records was unsuccessful as no records were made available for review. Requests for the staff records	PF CORRECTION DENTIFICATION NUMBER: A. BUILDING: MHL036-336 B. WING ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE W START 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 V 108 Continued From page 6 V 108 Review on 9/9/20 of Staff #4's record revealed: -Hire date of 7/1/120; -No documentation of training in client specific treatment plans. IN Review on 9/9/20 with Staff #5 revealed: -Hire date of 7/1/20; -No documentation of training in client specific treatment plans. IN Review on 9/9/20 with Staff #5 revealed: -Hire date of 6/24/20; -No documentation of training in client specific treatment plans. IN Review on 9/9/20 with Staff #5 revealed: -Hire date of 6/24/20; -No documentation of training in client specific treatment plans. IN Attempted review on 9/4/20 and 9/8/20 of Staff #6's records was unsuccessful as no records were made available for review. Requests for the staff records was unsuccessful as no records were made available for review. Requests for the staff records was unsuccessful as no records were made available for review. Requests for the staff records was unsuccessful as no records were made available for review. Requests for the staff records was uns	FCORRECTION IDENTIFICATION NUMBER: A BUILDING: COMM MHL036-336 B. WING 09 ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCE ID REACH DEFICIENCY OR IS DEPICIENCE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ADDRESS) REQUERTIFICENCY OR IS DEPICIENCES ID REACH DEFICIENCY OR IS TO PERCIENCES ID REACH CORRECTIVE ADDRESS Continued From page 6 V 108 CROSS-REFERENCE TO THE APPROPRIATE ORFORENCY OR USE TO PERCIENCE Continued From page 6 V 108 Recourd of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in client specific treatment plans. V 108 Review on 9/9/20 of Staff #4's record revealed: -Hire date of 7/1/20; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressive youth, or sexual trauma; -No documentation of training in human sexuality, sexually aggressi

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336			09	0/29/2020
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From page	e 7	V 108			
	sexually aggressive y -No documentation of treatment plans. Review on 9/8/20 of Client #2's Grandmod -No hire date recorde -No documentation of sexually aggressive y -No documentation of treatment plans. Review on 9/9/20 of revealed: -Hire date of 6/4/20; -No documentation of	f training in human sexuality, youth, or sexual trauma; f training in client specific Former Staff #11/Former ther's record revealed: ed; f training in human sexuality, youth, or sexual trauma; f training in client specific Former Staff #12's record f training in human sexuality,				
	-No documentation o treatment plans. Interview on 9/21/20 revealed:	youth, or sexual trauma; f training in client specific with Associate Professional				
	-Sexualized behavior meetings but never h deal with sexualized -Did not feel he need	he training he received; rs were discussed during lad any training on how to behaviors; led any additional trainings for a local Department of				
	unsuccessful. A pho	on 9/11/20 with Staff #4 was ne message was left at a call back. No call was ever 4.				
	Interview/Observation approximately 2:15pr	n on 9/11/20 at m with Staff #5 revealed:				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL036-336	B. WING		09	/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE			
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 108	Continued From page	e 8	V 108				
	-Was trained on sexu orientation but could discussed during the identify what "groomi sexualized behaviors -Did not respond what individualized treatme -Staff #5 had her phot the interview and whi the background. Sta answering questions was with someone effective Staff #5 denied being interview. Interview on 9/11/20 revealed: -Not a good time for was working at her o -"I start my Brighter II A) shift after so call m Attempted interview f #6 was unsuccessful the mailbox was full. the phone 2:11pm will series of text message DHSR surveyor cont informed she would b Interview on 9/11/20 -No training in sexua -No training in individu this job but had training treatment plans at an	aalized behaviors during not identify what was training and could not ng" was in relation to s; en asked about training on ent plans; one on speaker phone during ispering could be heard in ff #5 hesitated prior to . Staff #5 was asked if she se during the interview. g with anyone else during the at 12:36pm with Staff #6 an interview because she ther job; Dayz (Licensee/Sister Facility ne at 2(pm)." 9/11/20 at 2:10pm with Staff . There was no answer and A text message was sent to nich was read at 2:12pm. A ges between Staff #6 and the inued and Staff #6 was be contacted as needed. with Staff #8 revealed: lized behaviors; lualized treatment plans at ng in individualized					
	plan and sat and talk						

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336			09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, INTINGTON DRIVE	, ZIP CODE			
FRESH NE	EW START		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 108	Continued From page	e 9	V 108				
	-Never had access to Former Client #1;	lized behaviors; lualized treatment plans; o documents pertaining to r Client #1's diagnoses.					
	treatment plans or to clients;	Professional #1 and					
		ss referenced into 10A ope (V293) for a Type A1					
V 109	27G .0203 Privileging	g/Training Professionals	V 109				
	QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be no qualified professional (b) Qualified professionals professionals shall do and abilities required (c) At such time as a employment system then qualified professionals shall do	SSIONALS o privileging requirements for ls or associate professionals. ionals and associate emonstrate knowledge, skills by the population served. a competency-based is established by rulemaking, sionals and associate emonstrate competence. Il be demonstrated by including: edge; ess;					

Division of Health Service Regulation STATE FORM

6899

S6LM11

If continuation sheet 10 of 132

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE	09	/29/2020
			INTINGTON DRIVE			
RESH NE	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 10	V 109			
	NCAC 27G .0104 (18 met the requirements employment system i MH/DD/SAS. (f) The governing bo develop and implement for the initiation of an plan upon hiring each (g) The associate pro- supervised by a quali- population served for	skills; and ionals as specified in 10A 3)(a) are deemed to have a of the competency-based in the State Plan for dy for each facility shall ent policies and procedures individualized supervision in associate professional.				
	professionals (Licens Professional #1 and I Professional/Qualifier audited current assoc Professional) failed to skills, and abilities re- served. The findings	record review, and udited current qualified see #1/Director/Qualified Licensed d Professional #2) and 1 of 1 ciate professional (Associate o display the knowledge, quired by the population are:				
	Former Client #1, For Client #3, Former Client #5's records revealed -The initial assessme	/12/20 and 8/18/20 of rmer Client #2, Former ent #4, and Former Client d: ents completed by the /Qualified Professional #1				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
			A. BUILDING.	A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE			
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 109	Continued From page 11		V 109				
	and Licensee #2/Exe include presenting pr strengths, provisiona pertinent social, famil -No initial assessmer review for Former Cli -Former Client #1's tr did not include treatm hygiene issues, sexu outbursts including pi physical aggression, day camp; -Former Client #2's tr did not include treatm property destruction a -Former Client #3's tr did not include treatm running away, sexual of a summer day cam -Former Client #4's tr did not include treatm sexualized behaviors and the use of a sum Review on 9/9/20 of / #8, and Former Staff -There was no certific Associate Profession -Staff #8's certificate a person qualified to administration trainin -Former Staff #12's c illegible and had the written on the side m	ecutive Director did not oblems, needs and I or admitting diagnosis, and ly, and medical history; it was made available for ent #2; reatment plan dated 8/6/20 nent strategies to address alized comments, anger roperty destruction and and the use of a summer reatment plan dated 7/11/20 nent strategies to address and desire for self-harm; reatment plan dated 7/16/20 nent strategies to address lized behaviors, and the use np; reatment plan dated 8/6/20 nent strategies to address s, bullying, false allegations, imer day camp; Associate Professional, Staff #12's record revealed: cate of training provided for ial; did not have the signature of complete medication g; ertificate was dark and certificate holder name argin.					
	Interviews on 8/10/20 #1/Director/Qualified) - 9/25/20 with Licensee Professional #1 failed to					

S6LM11

If continuation sheet 12 of 132

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 12	V 109			
	identify all current an made by the Division Regulation (DHSR).	d former staff upon requests of Health Service				
	revealed: -Hire date not record -No documentation o sexually aggressive y -No documentation o treatment plans; -Trained himself in th MH/DD/SAS (Mental Disability/Substance 2/8/18, Person Cente Health and Safety da Competency dated 2 Confidentiality dated	Professional #1's record ed; f training in human sexuality, youth, or sexual trauma; f training in client specific e following topics: Health/Developmental Abuse Services) dated ered Thinking dated 2/7/18, ated 2/9/18, Cultural /10/18, Rights and				
	Description revealed -"Supervision of th and para-professiona emergencies, provisi psycho-educational s adolescents, particips meetings, coordinatio	Professional #1's Job e associate professionals als, oversight of on of direct services to children or ation in treatment planning on of each child or nt plan, provision of basic				
	-Nobody ever told the treatment plans or to clients;	with Licensee Professional #1 revealed: em to train on individualized pics to meet the needs of the ment strategies needed to				

STATE FORM

STATEMENT	of Health Service Regi OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
FRESH NE	W START	4460 HU	INTINGTON DRIVE			
		GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From pag	e 13	V 109			
	he developed and im	plemented to address the				
	needs of the former	•				
		edication administration				
		it a Registered Nurse				
	provided the training					
		, Personnel Registry and				
	Criminal Background					
	-	the original checks were				
		cord and replaced when				
	annual checks were					
	employee;					
		ick of proper staffing ratios				
	although evidence w					
		ick of services provided by				
		sional/Qualified Professional				
	#2 although evidence					
	-	ick of privacy on calls to legal				
		evidence was contradictory;				
	•	lge Former Client #3 was not				
		egation of abuse against				
	Staff #8;	5				
	-	delay and/or failure in				
		roperty of Former Client #1				
	and Former Client #4					
		ding the lack of incident				
	reporting;					
		ding the lack of training in				
		ictive Interventions and				
	Seclusion, Physical I	Restraint and Isolation				
	Time-Out for Staff #6					
	Finding #2					
		d 9/9/20 of the Licensed				
		d Professional #2's record				
	revealed:					
	-Licensed as a Clinic	al Mental Health Counselor.				
	Interview/Observatio					
		m - 3:10pm with Licensed				
	Professional/Qualifie	d Professional #2 revealed:				

Division of Health Service Regulation STATE FORM

6899

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-336	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RESH N	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From pag	e 14	V 109			
	since 2017; -Provided individual a weekly; -Used virtual session pandemic and resum the beginning of July -Last time at Sister F she saw Former Clie at the facility; -Upon confirming wit Professional/Qualifie last date of service w #2, the call was sudo 2:50pm; -Return calls to the L Professional/Qualifie made immediately u went to voicemail an requesting a return of -Call was returned by Professional/Qualifie who reported her cel -During the return ca Professional/Qualifies she made a mistake calendar correctly du date of service at the Former Client #2 was Facility A; -Will send copies of I Professional/Qualifies a secured and encry both facilities from 7/ 9/10/20. Based upon record r #2, #3, #4, and #5 an	Facility A was 9/2/20 when ant #2 who was the only client the the Licensed and Professional #2 that the was 9/2/20 to Former Client denly disconnected at Licensed and Professional #2's phone pon disconnection of the call d a message was left call; y the Licensed and Professional #2 at 2:57pm I phone battery went dead; all, the Licensed and did not view her uring the initial call. The last e facility was 8/2/20 when s the only client at Sister Licensed and Professional #2's notes via pted email for all clients at (1/20-present by 9pm on eviews of Former Clients #1, and their respective discharge o clients in the facility on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COM	E SURVEY PLETED	
		MHL036-336	B. WING		09	9/29/2020	
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, 2	ZIP CODE			
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 109	Continued From page	e 15	V 109				
	identified this as the laforementioned reco Former Clients #1, #2 present in the facility Licensed Professiona identified only Forme Review on 9/11/20 of DHSR surveyor from Professional/Qualifie 9/10/20 at 6:54pm re "Good evening, I'm w conversation on this work and do not fore requested document I will have this inform	d Professional #2 dated vealed: vanted to follow up per our afternoon. I still currently at see being able to get you the ation this evening. However, ation to you no later than I come in from work as I do					
	DHSR surveyor from Professional/Qualifie 9/11/20 at 8:09pm re -Clinical notes on Foo #4 (Former Client #5 two days) were sent secure and encrypted	d Professional #2 dated vealed: rmer Clients #1, #2, #3 and was only at the facility for via an attachment to a d email; f clinical services provided to					
	Clients #1, #2, #3, ar -The Licensed Profes	ssional/Qualified ot provide weekly sessions with Licensee					

Division of Health Service Regu STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 109	Continued From pag	e 16	V 109			
	Sessions were condu	ssional/Qualified at the facility weekly. ucted virtually during the start then returned to in-person				
	Finding #3 Review on 9/9/20 of Associate Professional's record revealed: -Hire date of 7/1/19.					
	Job Description reve -Duties included: " day operations of the direct care staff rega to the implementation adolescent's treatme service planning mee assessment and pro- teen/parents which in and needs of client, s family, review of meo scheduling of assess	Management of the day to e group home, supervision of rding responsibilities related n of each child or ent plan, participation in etings, conduct initial gram orientation session with ncludes identifying strength strengths and needs of dications, assessment of sment and contact with Participate in development of				
	revealed: -Worked as Associat -Filled in as Qualified -Sexualized behavior meetings but never h deal with sexualized -Did not feel he need because he worked f Social Services;	d Professional as needed; rs were discussed during had any training on how to behaviors; led any additional trainings for a local Department of or when the clients would in the Licensed				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
		MUL 020 020	B. WING					
	ROVIDER OR SUPPLIER	MHL036-336	ADDRESS, CITY, STATE		03/23/2020			
				, 0002				
FRESH NI	EW START	GASTO	NIA, NC 28056					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE		
V 109	Continued From page	e 17	V 109					
		pervised by having the alls on speaker phone for alls.						
	-	ss referenced into 10A ope (V293) for a Type A1						
V 110	27G .0204 Training/S Paraprofessionals	Supervision	V 110					
	SUPERVISION OF F (a) There shall be no paraprofessionals. (b) Paraprofessional associate professional associate professional professional as speci Subchapter. (c) Paraprofessional knowledge, skills and population served. (d) At such time as a employment system then qualified profess professionals shall de (e) Competence sha exhibiting core skills (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making (5) interpersonal ski (6) communication s (7) clinical skills. (f) The governing bo develop and impleme	fied in Rule .0104 of this s shall demonstrate l abilities required by the a competency-based is established by rulemaking, sionals and associate emonstrate competence. Il be demonstrated by including: dge; ss; ; ; Ils; skills; and dy for each facility shall ent policies and procedures e individualized supervision						

Division of Health Service Regulation STATE FORM

6899

STATEMENT	of Health Service Reg TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	D THE APPROPRIATE	COMPLET DATE
V 110	Continued From pag	je 18	V 110			
	This Rule is not met	t as evidenced by:				
		and record review, 1 of 7				
	-	professionals (Licensee				
		or) failed to display the				
	knowledge, skills, ar population served.	nd abilities required by the The findings are:				
	Review on 9/8/20 an	nd 9/9/20 of Licensee				
	#2/Executive Director	or's record revealed:				
	-Hire date of 8/1/18;					
	-Did not ensure nece needs of the clients.	essary training to meet the				
	Review on 9/14/20 c Director's Job Descr	of Licensee #2/Executive				
		upervise employees at three				
		mes, assist with employee				
		nd reviews, coordinate				
		n the residential programs,				
		with policy and procedures,				
	maintain positive pro	e development of new				
		ate in treatment team				
		/7 based on the program's				
	U	tively participate in and lead				
	program meetings w					
	supervisors/manage	rs, participate in your own				
		nent meetings with agency				
		d coordinate quality training				
		ving the ability to train on all				
		ns and on other suggested the-job training to newly hired				
		s overall staff development,				
ision of Lloy	alth Service Regulation					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pag	e 19	V 110			
	utilize problem solvin emergency situations the QA/QI (Quality A Improvement) comm Intervention Advisory fatalities" Review on 8/11/20, & Former Client #1, Fo Client #3, Former Cli #5's records revealed -The initial assessme Licensee #1/Director and Licensee #2/Exe include presenting pr strengths, provisional pertinent social, fami -No initial assessment review for Former Cli -Former Client #1's to did not include treatm hygiene issues, sexu outbursts including p physical aggression, day camp; -Former Client #2's to did not include treatm property destruction	ng skills to manage s/disaster plan review, sit on ssurance/Quality ittee, client rights as well as r committee, review all 8/12/20 and 8/18/20 of rmer Client #2, Former ent #4, and Former Client d: ents completed by the /Qualified Professional #1 ecutive Director did not roblems, needs and I or admitting diagnosis, and ly, and medical history; nt was made available for				
	did not include treatn	nent strategies to address lized behaviors, and the use				
	did not include treatn	reatment plan dated 8/6/20 nent strategies to address s, bullying, false allegations, nmer day camp;				
	#8, and Former Staff	Associate Professional, Staff #12's record revealed: cate of training provided for				

Division of Health Service Reg

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 110	Continued From pag	e 20	V 110			
	Associate Profession -Staff #8's certificate a person qualified to administration trainin -Former Staff #12's of illegible and had the written on the side m Refer to 10A NCAC 2 Requirements (V118 Interviews on 9/2/20- members at the local Former Client #1 and summer day camp re -Were informed Form Client #A1 were from -"Was not made awa	hal: did not have the signature of complete medication g; certificate was dark and certificate holder name hargin. 27G .0209 Medication) for specifics. -9/4/20 with management I recreational facility where d Former Client #A1 attended evealed: mer Client #1 and Former n a foster home;				
	girls (Former Client # -Licensee #2/Execut	e needs of the girls when				
	#2/Executive Directo	0 - 9/25/20 with Licensee r failed to identify all current n requests made by the ervice Regulation.				
	Director revealed: -Nobody ever told the treatment plans or to clients;	with Licensee #2/Executive em to train on individualized meet the needs of the				
	presenting problem,	essments needed to include needs and strengths, ng diagnosis, and pertinent edical history;				

The RESULTORY OR LSC IDENTIFYING INFORMATION) The CROSS-REFERENCED TO THE APPROPRIATE DATE V110 Continued From page 21 V110 V111 </th <th></th> <th>OF DEFICIENCIES</th> <th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th> <th>(X2) MULTIPLE C</th> <th></th> <th></th> <th>E SURVEY PLETED</th>		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
WHE OF IPROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE desp HARMON STATEMENT OF DESTINATION OR REVE GASTONIA, NC 28055 PHID PRETAX Continued From page 21 U110 V110 Continued From page 21 V110 V110 Continued From page 21 V110 -Ucense # V1Director/Qualified Professional #1 signed Staff #85 V110 -Ucense # V1Director/Qualified Professional #1 signed Staff #85 V110 -Ominand Background checks were removed from the record and replaced when annual checks were completed on each employee; V110 -Denied there was lack of prozer staffing ratios although evidence was contradictory; -Denied there was lack of profees provided by the Licensed #0 rediene rule record and replaced when annual checks were completed on each employee; -Denied there was lack of profees staffing ratios although evidence was contradictory; -Denied there was lack of profees provided by the Licensed Professional/Cualified Professional #22s although evidence was contradictory; -Denied there was lack of profees provided by the Licensed Professional/Cualified Professional #25 although evidence was contradictory; -Denied there was lack of profeer staffing ratios although evidence was contradictory; -Denied there was a delay and/or failure in returning parsonal property of Former Client #1 and Former Client #4; -No comments regarding the lack of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restriant and Isolation Time-Out for Staff #6. V111				A. BUILDING:			
Here: The summary statement of exploring and the providers plan of consection (section of the providers plan of consection) (section of the providers plan of the provider provided the training (section of the provider provided the training) (section of the provider plan of the provider provided the training (section of the provider provided the training) (section of the provider provided the training) (section of the provided professional (Wallifer Professional) (Wa			MHL036-336	B. WING		09/29/2020	
CASTONIA, NC 28056 (M) D PRETX NG SUMMARY STREEMENT OF DEPICIENCIES (EXCH DEPICIENT VIUSI DE PRECIDE NY ILL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREVX PREVX NG D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO IN APPROPRIATE DEPICIENCY) ODE CROSS-REFERENCE DEPICIENCY) V110 Continued From page 21 V110 V110 -Was not aware treatment strategies needed to be developed and implemented to address the needs of the former clients; -Licensee #1/Director/Qualified Professional #1 signed Staff #05 medication administration training certificate but a Registrer All Criminal Background checks were out of compliance because the original checks were removed from the record and replaced when annual checks were completed on each employee; -Denied three was lack of prooper staffing ratios atthough evidence was contradictory; -Denied there was lack of prooper staffing ratios atthough evidence was contradictory; -Denied there was lack of prooper calls to legal guardians although evidence was contradictory; -Denied there was a delay and/or failure in returning personal property of Former Client #1 and Former Client #2; -No comments regarding the lack of incident reporting; -No comments regarding the lack of incident reporting; -No comments regarding the lack of incident reporting; -No comments regarding the lack of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint and Isolation Time-Out for Staff #0. V111	NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MADD Mode SubMADD VARIENT OF GEROLENCES. Incomparison of the comparison of thecomparison of the comparison of the comparison of the co	RESH NE	EW START					
-Was not aware treatment strategies needed to be developed and implemented to address the needs of the former clients; -License #1/Director/Qualified Professional #1 signed Staff #8's medication administration training certificate but a Registered Nurse provided the training; -Many Health Care Personnel Registry and Criminal Background checks were out of compliance because the original checks were removed from the record and replaced when annual checks were completed on each employee; -Denied there was lack of proper staffing ratios although evidence was contradictory; -Denied there was lack of services provided by the Licensed Professional/Qualified Professional #2's although evidence was contradictory; -Denied there was lack of services provided by the Licensed Professional/Qualified Professional #2's although evidence was contradictory; -Denied there was lack of proyer yon calls to legal guardians although evidence was contradictory; -Denied there was aleck of privacy on calls to legal guardians although evidence was contradictory; -Denied there was a delay and/or failure in returning personal property of Former Client #1 and Former Client #4; -No comments regarding the lack of rincident reporting: -No comments regarding the lack of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint and Isolation Time-Out for Staff #6. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. V111	PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES	ID PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE	COMPLETE
be developed and implemented to address the needs of the former clients; i.censee #1/Director/Qualified Professional #1 signed Staff #8's medication administration training certificate but a Registered Nurse provided the training; Many Health Care Personnel Registry and Mini Background checks were out of compliance because the original checks were removed from the record and replaced when annual checks were completed on each employee; -Denied there was lack of proper staffing ratios although evidence was contradictory; -Denied there was lack of proger staffing ratios although evidence was contradictory; -Denied there was lack of proyen staffing ratios guardians although evidence was contradictory; -Denied there was lack of proyen on calls to legal guardians although evidence was contradictory; -Failed to acknowledge Former Client #3 was not protected after an allegation of abuse against Staff #8; -Denied there was a delay and/or failure in returning personal property of Former Client #1 and Former Client #4; -No comments regarding the lack of incident reporting; -No comments regarding the lack of incident reporting; -No comments regarding the lack of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint an	V 110	Continued From pag	e 21	V 110			
		be developed and im needs of the former of -Licensee #1/Directo signed Staff #8's mea- training certificate bu provided the training -Many Health Care F Criminal Background compliance because removed from the rea annual checks were employee; -Denied there was la although evidence w -Denied there was la the Licensed Profess #2's although eviden -Denied there was la guardians although e -Failed to acknowled protected after an all Staff #8; -Denied there was a returning personal pr and Former Client #4 -No comments regar reporting; -No comments regar Alternatives to Restri Seclusion, Physical F Time-Out for Staff #6 This deficiency is cro	applemented to address the clients; r/Qualified Professional #1 dication administration at a Registered Nurse personnel Registry and checks were out of the original checks were cord and replaced when completed on each ck of proper staffing ratios as contradictory; ck of services provided by sional/Qualified Professional ce was contradictory; ck of privacy on calls to legal evidence was contradictory; ge Former Client #3 was not egation of abuse against delay and/or failure in roperty of Former Client #1 4; ding the lack of incident ding the lack of training in ictive Interventions and Restraint and Isolation 5.				
Assessment/Treatment/Habilitation Plan	V 111	. ,	ent/Habilitation Plan	V 111			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336		7/0.0005	09	9/29/2020
IAIVIE OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 111	Continued From page	e 22	V 111			
	PLAN (a) An assessment sclient, according to g the delivery of service be limited to: (1) the client's prese (2) the client's need (3) a provisional or a established diagnosis of admission, except detoxification or othe shall have an establis admission; (4) a pertinent social and (5) evaluations or as psychiatric, substance vocational, as approp (b) When services a establishment and im treatment/habilitation referred to as the "pla client's presenting pro-	ITATION OR SERVICE shall be completed for a overning body policy, prior to es, and shall include, but not enting problem; s and strengths; admitting diagnosis with an s determined within 30 days that a client admitted to a r 24-hour medical program shed diagnosis upon al, family, and medical history; essessments, such as the abuse, medical, and oriate to the client's needs. re provided prior to the oplementation of the or service plan, hereafter an," strategies to address the oblem shall be documented.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	E CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 111	Continued From page	e 23	V 111			
	prior to the delivery o	f services and assessments				
	prior to the delivery of services and assessments ncluded presenting problem, needs and					
		l or admitting diagnosis, and				
	0	ly, and medical history				
		ed former clients (Former				
		4, and #5). The findings are:				
	Gilonto #1, #2, #0, #4	, and $\pi \circ j$. The infullitys are.				
	Review on 8/28/20 of	f the facility's undated				
	Assessment Policy re					
		s assessed to appropriately				
	identify his/her needs					
	appropriate, the need	•				
	consumer. A clinical					
		creening/assessment/evaluation is conducted				
	•	no presents himself/herself				
	or services and/or is referred for assessment,					
	treatment, or evaluat	-				
		admission and disposition for				
	additional treatment	•				
		cal Assessment (CCA) will				
		30 days of admission.				
		ded to Brighter Dayz, LLC				
		oon referral in order to be				
	considered for treatm					
		be conducted prior to				
	admission by the QP	-				
	Professional/License					
	Counselor/Executive	Director). The screening				
		ne, faxed over information or				
	in person with the ref					
	parent/guardian. It w	vill be documented on the				
	screening form. Screening	eening information is also on				
	the residential application	ation completed by the				
	guardian upon admis	sion. When a client is				
	admitted to the Brigh	ter Dayz Group Home, an				
		essment will be completed.				
	This assessment will	include the client's name,				
	date of screening, cli	ent triggers, interventions				
		ut from LPC if applicable,				
	and presenting proble	/ .	1			1

STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336	B. WING		09	09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
FRESH NI	EW START		INTINGTON DRIVE				
	1		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 111	Continued From pag	e 24	V 111				
	CCA)"						
	Former Client #1's re -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disr Disorder and Attentic Disorder; -11 years old; -Initial Assessment c #1/Director/Qualified 12/26/19 did not include prese strengths, provisiona pertinent social, fami	8/12/20 and 8/18/20 of ecord revealed: uptive Mood Dysregulation on Deficit Hyperactivity ompleted by the Licensee Professional #1 dated nting problems, needs and I or admitting diagnosis, and ly, and medical history; e residential application were					
	Former Client #2's re -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Pos and Attention Deficit -9 years old;	8/12/20 and 8/18/20 of ecord revealed: t Traumatic Stress Disorder Hyperactivity Disorder; nt was available for review.					
	made available for re requested via email of second email request 4:06pm as a reminder sent to Licensee #1/I Professional #1 and Director. On 8/17/20 #2/Executive Director	Licensee #2/Executive) at 3:45pm, Licensee r called and revealed /Qualified Professional #1					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (; A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE			
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 111	Continued From page	e 25	V 111				
	Director was still out	nts. Licensee #2/Executive of town assisting with a eral arrangements. No vided.					
F 	Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #3's record revealed: -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder,						
	Oppositional Defiant -13 years old; -Initial Assessment co	Disorder, Depression; ompleted by the Licensee Professional #1 dated					
	strengths, provisiona pertinent social, fami	nting problem, needs and l or admitting diagnosis, and ly, and medical history; e residential application were					
	Former Client #4's re -Admitted 4/24/20; -Discharged 8/6/20;	/12/20 and 8/18/20 of cord revealed: positional Defiant Disorder					
	#2/Executive Directo	ompleted by the Licensee r dated 4/23/20					
		s and strengths, provisional s, and pertinent social, iistory.					
	Review on 8/11/20, 8 Former Client #5's re -Admitted 8/5/20; -Discharged 8/7/20; -Diagnosed with Pos	/12/20 and 8/18/20 of cord revealed:					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
			A. BUILDING.			
		MHL036-336	B. WING		09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
FRESH NI	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 111	Continued From pag	e 26	V 111			
	Unspecified Trauma; -10 years old; -Initial Assessment w 8/5/20 did not include provisional or admitti social, family, and m Interview on 8/27/20 #1/Director/Qualified Licensee #2/Executiv -The policy for assess facility receives a CC Then, the facility com assessment on each with the strengths an universal residential referring party (exam Social Services) wor to a higher or lower for Addendum complete Professional/Qualifie	with unclear signature dated e needs and strengths, ng diagnosis, and pertinent edical history. with Licensee Professional #1 and we Director revealed: sments is as follows: The CA with a referral application. npletes its own initial client and combines that d needs list from the application completed by the iple: DSS (Department of ker). Finally, upon discharge evel of care there is a CCA				
	assessments needed problem, needs and admitting diagnosis, and medical history; -The facility had been assessments by com	Professional #1 and ve Director revealed: ive Director was not aware d to include presenting strengths, provisional or and pertinent social, family, in developing initial ubing copies of the residential d by the referring party with the following items: or you?"				

Division of Health Service Regula STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
	1		NIA, NC 28056			
(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	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 111	Continued From page	27	V 111			
	way?" -"What are things you -"Do you understand -"Do you have concer -"Present problems;" -The facility will ensur comprehensive initial information required in	why you are here?" "ns?" re to complete a more assessment with all				
		ss referenced into 10A ope (V293) for a Type A1				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for client receive services beyond (d) The plan shall inco (1) client outcome(s) achieved by provision projected date of achie (2) strategies; (3) staff responsible; (4) a schedule for re annually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a	TATION OR SERVICE developed based on the artnership with the client or erson or both, within 30 days ts who are expected to ond 30 days. clude:) that are anticipated to be of the service and a ievement; view of the plan at least on with the client or legally r both; ion or assessment of				

D STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE COMF	SURVEY
			B. WING			
		MHL036-336		09	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NI	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From pag	e 28	V 112			
	failed to develop and address the needs o	implement strategies to f the clients affecting 4 of 4 s (Former Clients #1, #2, #3,				
	Former Client #1's re -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disr	8/12/20 and 8/18/20 of ecord revealed: ruptive Mood Dysregulation on Deficit Hyperactivity				
	-11 years old; -Undated Residentia assaultive, "extren and kick things throw shower"	I Application revealed ne aggressionrage will hit / thingsdoes not like to ompleted by the Licensee				
	#1/Director/Qualified 12/26/19 revealed: " behaviors in the past -Discharge Summary	Professional #1 dated Possible sexualized ;" / completed by the Licensee				
	8/6/20 revealed diffic boundaries and pers poor hygiene, and in	Professional #1 dated sulty with respecting onal space, struggles with cidents of profanity, property bal and physical aggression;				
vision of Ha	-Treatment Plan upd	ate for July, 2020 revealed de up stories while attending				

TATEMENT OF DEFICIENCIES (X ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, INTINGTON DRIVE	ZIP CODE		
FRESH NE	W START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
V 112	Continued From pag	ge 29	V 112			
	a summer day camp intercourse in the pa property destruction physical aggression concerns were repo behaviors of being u resulting in property defiance at least 4 to -Treatment plan upo treatment strategies sexualized commen including property d aggression. Further treatment strategies summer day camp. Review on 8/11/20, Former Client #2's r -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Pot and Attention Deficit -9 years old; -Treatment plan upo of property destruction but did not include s destruction and self Review on 8/11/20, Former Client #3's r -Admitted 6/12/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20;	 about having sexual ast. Anger outbursts including had increased as well as towards staff. Unspecified rted by camp staff. Client had inable to control her impulses destruction, disrespect, and to 5 times per week; late 8/6/20 did not include for hygiene issues, ts, or anger outbursts estruction and physical rmore, there were no regarding placement at a 8/12/20 and 8/18/20 of ecord revealed: st Traumatic Stress Disorder thyperactivity Disorder; late 7/11/20 revealed a history on and desire for self-harm strategies to address property -harm. 8/12/20 and 8/18/20 of 				
	history of running av	al Application revealed a way and sexually iors with "increased				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-336	B. WING		09/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
RESH NE	W START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From page	e 30	V 112			
	#1/Director/Qualified revealed Former Clie running away; -Discharge Summary #1/Director/Qualified 8/4/20 revealed Form from the facility prem sexual assault alleg and unsubstantiated -Comprehensive Clin addendum completed Professional/Qualified 8/17/20 revealed: " boundaries and she t inappropriately often hugging without perm -Treatment Plan date of running away requir has had a recent incr behaviors by frequen reporting she is havir is not able to maintait and will touch others Client feels that this i Client storms out of upset, yelling and usi also demonstrates di appropriate boundari staff and peers" T include strategies to a sexualized behaviors	ompleted by the Licensee Professional dated 6/11/20 ent #3 had a history of a completed by the Licensee Professional #1 dated her Client #3 walked away ises several times and a " gation was filed against client ;" ical Assessment (CCA) d by the Licensed d Professional #2 dated has no understanding of couches people rubbing on them and hission" ed 7/16/20 revealed a history iring reports to law e, 2020, she ran away and tranger and left for a "long ing police intervention. She rease in sexualized tly talking about sex and ng sex with peers. "Client n appropriate boundaries and will 'smell' others. s a great personality trait f the home when she is ing foul languageClient				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-336	B. WING		09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FRESH NI	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 112	Continued From page	e 31	V 112			
	and Unspecified Trau -13 years old; -Initial Assessment of #2/Executive Director [Former Client #4] ha other peers[Forme not take responsibility Client #4] was caugh previous placements stories and tell them mom to file reports ag wants to move to a n -CCA Addendum com Professional/Qualified 8/1/20 revealed client intimacy, sexual abus sexually inappropriate Client #4] makes sex displays sexual gestu physically and verbal and peers at group he bullies younger peers constantly lies on sta be sent home;" -Discharge Summary #1/Director/Qualified 8/6/20 revealed a his clothing, struggles wi assault by pushing a sexual assault allega -Treatment Plan upda Client #4 manifested factual and continues pushed a client off a client's personal pictu	positional Defiant Disorder ima; ompleted by the Licensee r dated 4/23/20 revealed: " is destroyed property of r Client #4] lies daily and will y for her action. [Former t kissing her room mate in [Former Client #4] creates to her mom, wanting her gainst others when she ew placement" npleted by the Licensed d Professional #2 dated t has difficulty with sexual se/rape, and displays e behaviors and "[Former ual comments to peers and ures[Former Client #4] is ly aggressive towards staff ome[Former Client #4] s in the group homeShe ff and peers in her attempt to r completed by Licensee Professional #1 dated tory of stealing peers' th telling the truth, physical peer off the couch, and a				

Division of Health Service Regulat STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From pag	e 32	V 112			
	plan did not include s sexualized behaviors allegations. Furtherr treatment strategies summer day camp.	s, bullying, and false				
	Interviews on 8/14/20 and 9/14/20 with Former Client #1 revealed: -The former clients attended summer day camps; -Attended a summer day camp at a local recreational facility with Former Client #A1; -Behaved herself while at summer day camp; -Engaged in physical fights with peers at the facility; -Former Clients played in each other's rooms and					
	there was at least on	ed in each other's rooms and e incident of sexualized former Client #2 and Former				
	members at the local Former Client #1 and summer day camp re	ner Client #1 and Former				
	-"Was not made awa challengesnot to th be briefed;" -Cannot provide serv	re of their needs or ne extent we would want to rices effectively if the staff				
	-After the incident be Former Client #A1, tl needs of the camper	needs of the children; tween Former Client #1 and ne camp staff realized the s were greater than what the				
	during the day;	dle; d not stay with the campers physically assaulted" Former				
	Client #1 and "the gii -"We just had very lir	Is were in a violent fight;" nited information about the 1 and Former Client #A1);				

Division of Health Service Regula STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		JNTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From pag	e 33	V 112			
	had previously been camp in a second ne under the same pare -Licensee #2/Execut forthcoming about th registering the girls fr -The camp employed a degree in psycholo counseling. The coor coaching campers du The level of coaching redirection during a c involve breaking up p campers.	ive Director was not e needs of the girls when				
	behaviors between F Client #4.	e incident of sexualized Former Client #2 and Former				
	revealed: -Attended a summer -Was transported to Associate Profession different days;	the summer day camp by nal, Staff #5 and Staff #9 on				
	when the director of discovered Former C altercation with Form	stay in camp all summer the summer camp Client #3 was in a physical her Client #A1 which led to abbing Former Client #3 in				
	stabbed me in the th fought her back;"	ck (to camp) because a girl roat and choked me and I Client #4 punch Former				

Division of Health Service Regula STATE FORM

6899

If continuation sheet 34 of 132

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE CC	
V 112	Continued From pag	e 34	V 112			
	-Former Client #4 en behaviors with peers -Former Client #3 on and went down the re asked her questions She told him she was said "f**k on!" Former from the man and wa police were not involv Interview on 8/19/20 Department of Socia revealed: -Had multiple concer -Former Client #3 ha behaviors. She liked and was sexually act was a history of sexu history of inappropria allowed former client highly sexualized lyri contemporary dance gestures; -Former Client #3 att which the DSS Socia the middle of July, 20 informed she could n verbal altercation wit -Never received door happened at the carr Interview on 8/25/20 Adoption Recruiter re -Former Client #3 att because she was mo to her behaviors.	gaged in sexualized ; ce ran away from the facility oad. She met a man who and asked how old she was. s 13-years-old and the man r Client #3 walked away alked back to the facility. The ved in the incident. with Former Client #3's I Services Social Worker ns with the facility; d a history of sexualized I to talk about sex all the time ive with her boyfriend. There ialized conversations but no ate touching. Facility staff s to listen to songs with cs and dance a consisting of sexualized ended a cheerleading camp al Worker found out about in 020. Former Client #3 was not return to camp due to a h staff at the camp; umentation regarding what np. with Former Client #3's				
	revealed:	as kicked out of summer day				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(275)
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From page	e 35	V 112			
	camp for kissing boys -Former Client #1 att -Was in a peer's bed sexualized behaviors Interview on 8/12/20 Social Worker reveal -Many clients from th summer day camps. Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -Was not aware treat be developed and im needs of the clients; -Will ensure all treatm corresponding strates treatment plans in the	as kicked out of summer day s; ended summer day camp; room and engaged in a with Former Client #2. with Former Client #4's DSS ed: the facility were sent to with Licensee Professional #1 and ve Director revealed: ment strategies needed to uplemented to address the nent needs with gies are included in the				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician.					

Division of Health Service Regulation STATE FORM

6899

S6LM11

If continuation sheet 36 of 132

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		MHL036-336	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 36	V 118			
	pharmacist or other I privileged to prepare (4) A Medication Adm all drugs administere current. Medications recorded immediatel MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for a (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be reco	trained by a registered nurse, egally qualified person and and administer medications. ninistration Record (MAR) of ed to each client must be kept administered shall be y after administration. The e following: and quantity of the drug; dministering the drug; e drug is administered; and if person administering the or medication changes or rded and kept with the MAR opointment or consultation				
	failed to ensure staff medication administr registered nurse, pha qualified person affe staff (Associate Profe	and record review, the facility				
	record revealed: -Hire date 7/1/19;	Associate Professional's				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING		00/00/0000	
NAME OF PI	ROVIDER OR SUPPLIER	MHL036-336	DDRESS, CITY, STATE	09	/29/2020	
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RESHIN	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 37	V 118			
	administration.					
	revealed: -Hire date of 6/5/20; -Medication administ dated 5/26/20. The r clear. The trainer's s does not match the e other medication adm certificates for the ag signature is similar to #1/Director/Qualified An additional copy of administration trainin via email on 9/10/20 request was sent to I #1/Director/Qualified Licensee #2/Executiv request revealed the	pency. The trainer's of the signature of Licensee Professional #1. If Staff #8's medication og certificate was requested at 12:31pm. The email Licensee Professional #1 and we Director. The email need for an "additional copy ation certificate (the one ifficult to read)." No				
	revealed: -Hire date of 6/4/20; -Medication administ 5/28/20 signed by the completed medicatio the agency. The cer to read. Former Stat written on the side of	Former Staff #12's record ration certificate dated e Registered Nurse who n administration training for tificate was dark and difficult ff #12's name was hand f the certificate. with Associate Professional				
	revealed: -Could not recall all t believed he may hav	he trainings he received but be been trained in medication build not recall who provided				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 38		V 118			
	the training.					
	Interview on 9/11/20 with Staff #8 revealed: -Employed as a Direct Care Worker and would step in as House Manager as needed; -Received training in medication administration but cannot recall who completed the training; -Recalled staff at the facility helped with medication administration training.					
	revealed: -Worked various shif Facility A; -Had been employed -Never received train administration becau technician from anot -Never met with a Re the facility;	use she was a medication				
	who provided the ag medication administr phone number for th requested via email Licensee #1/Director	with the Registered Nurse ency's previous training for ration was unsuccessful. The e Registered Nurse was on 9/10/20 at 2:44pm from r/Qualified Professional #1 ecutive Director. There was equest.				
	signed Staff #8's me training certificate bu provided the training	Professional #1 and ve Director revealed: n/Qualified Professional #1 dication administration tt a Registered Nurse				

STATE FORM

6899

If continuation sheet 39 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
V 118	Continued From pag	e 39	V 118			
		ple trainings they received; d in medication administration se.				
		oss referenced into 10A cope (V293) for a Type A1				
V 131	G.S. 131E-256 (D2) Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring he health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a nall access the Health Care and shall note each incident ropriate business files.				
	failed to ensure the H Registry (HCPR) wa documented prior to affecting 7 of 10 aud #1/Director/Qualified #2/Executive Director Staff #8, and Staff #8 staff (Former Staff #	as evidenced by: and record review, the facility Health Care Personnel s accessed and the results an offer of employment ited current staff (Licensee Director #1, Licensee or, Staff #4, Staff #5, Staff #6, 9) and 2 of 2 audited former 11/Former Client #2's ormer Staff #12). The				
	Review on 9/8/20 an	d 9/9/20 of Licensee				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		MHL036-336			09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 131	Continued From pag	e 40	V 131			
	#1/Director/Qualified Professional #1's record revealed:-Hire date not recorded;-HCPR check completed on 1/30/19.					
	with the Division of H (DHSR) for the facilit -Licensee #1/Directo was identified on the	r/Qualified Professional #1				
	with DHSR for Sister -Licensee #1/Directo was identified on the	r/Qualified Professional #1				
	Review on 9/8/20 an #2/Executive Directo -Hire date of 8/1/18; -HCPR check comple	r's record revealed:				
	-Hire date of 7/1/20; -HCPR check comple	Staff #4's record revealed: eted 6/23/20; npleted between 6/16/20 and				
	Review on 9/9/20 wit -Hire date of 6/24/20 -HCPR completed 6/ -Agency training com 6/24/20.	· · ·				
	#6's records was uns	9/4/20 and 9/8/20 of Staff successful as no records for review. Requests for the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336	B. WING		09	0/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
V 131	Continued From page	e 41	V 131				
	9:53am for the record again on 9/8/20 at 1: sent via secured and Review on 9/8/20 and revealed: -Hire date of 6/5/20; -HCPR check comple -Agency training com 6/3/20. Review on 9/8/20 and revealed: -Hire date of 12/27/19 -No HCPR check com Review on 9/8/20 of Client #2's Grandmod -No hire date recorde -HCPR check comple -Agency training com Review on 9/9/20 of revealed: -Hire date of 6/4/20; -HCPR check comple	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be encrypted email. d 9/9/20 of Staff #8's record eted 6/3/20; npleted between 5/20/20 and d 9/9/20 of Staff #9's record 9; mpleted. Former Staff #11/Former ther's record revealed: ed; eted 6/16/20; npleted in 2018 and 2019. Former Staff #12's record					
	unsuccessful. A pho	on 9/11/20 with Staff #4 was ne message was left at a call back. No call was ever 4.					
	-Could not identify th	with Staff #5 revealed: e specific date employment it was in Spring, 2020.					

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI
V 131	Continued From page	e 42	V 131			
	Interview on 9/11/20 -Start date was 5/5/2	with Staff #8 revealed: 0.				
	Interview on 9/2/20 with Former Staff #12 revealed: -Start date was 5/22/20.					
	which they were finan a bonus; -The hire date in the were officially hired a -Many HCPR checks because the original removed from the rec annual HCPR checks employee; -Will complete HCPR staff; -Will keep original HC record in the future.	Professional #1 and ve Director revealed: and received training for ncially compensated through record reflected when they fter training was completed; were out of compliance				
V 132	REGISTRY (g) Health care faciliti		V 132			
	health care personne	el, including injuries of ch appear to be related to				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 43 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		MHL036-336	B. WING		09/29/2020		
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE			
RESH NE	W START		NTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 132	Continued From page	e 43	V 132				
	 (which includes: a. Neglect or abuse facility or a person to as defined by G.S. 13 as defined by G.S. 13 b. Misappropriation in a health care facilit (b) of this section incl care services as defin hospice se	s belonging to a health care or client. Health care facility or against whom the employee is evidence that all alleged and must make every effort from harm while the gress. The results of all e reported to the e working days of the initial					
	This Rule is not met Based on interview a	as evidenced by: nd record review, the facility					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		JNTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 132	Continued From page 44		V 132			
	Department and faile harm during the inve- audited current staff Review on 8/11/20, 8 Former Client #3's re -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atte Disorder, Post Traum Oppositional Defiant -13 years old. Review on 9/8/20 and revealed: -Hire date of 6/5/20. Review on 8/12/20 a Incident Reports data -No incident reports of	egations of abuse to the d to protect clients from stigation affecting 1 of 10 (Staff #8). The findings are: a/12/20 and 8/18/20 of cord revealed: ntion Deficit Hyperactivity natic Stress Disorder, Disorder, Depression; d 9/9/20 of Staff #8's record nd 8/13/20 of the facility's ed 7/1/20 - 8/7/20 revealed: regarding an allegation of #8 choking Former Client				
	-The local Department was in process of inv abuse involving Staff #3; -Did not believe there allegation. Interview on 8/14/20 revealed:	with Licensee Professional #1 revealed: Int of Social Services (DSS) restigating an allegation of #8 choking Former Client was any truth to the with Former Client #1				
	staff. Interview on 9/3/20 w revealed:	vith Former Client #3				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-336			09	9/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
RESH NE	EW START		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 132	Continued From page 45		V 132				
	-"One day [Staff ## hands on my throat b was in the van at [Sis remember who was of Interview on 8/19/20 Social Worker reveal -Upon arrival at the fa Client #3 on 8/4/20, F from the facility with 3 member, and other c -Was deeply concern was in the presence who had allegedly ch Interview on 8/13/20 revealed: -Staff #8 put her hand throat and tried to ch -The incident occurre Facility A; -Staff #8 and Former each other; -Former Client #3 late because she liked St Interview on 9/11/20	 B) got really mad and put her put did not really choke me. I ster Facility A]Cannot driving the van" with Former Client #3's DSS ed: acility to pick up Former Former Client #3 was away Staff #8, a second staff lients; hed that Former Client #3 of the same staff member toked her. with Former Client #4 ds around Former Client #3's oke her; ed on the driveway of Sister Client #3 were cursing at er denied the incident aff #8. with Staff #8 revealed: hands around Former Client 					
		ve Director revealed: oss referenced into 10A ope (V293) for a Type A1					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PRO	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	N START		INTINGTON DRIVE NIA, NC 28056			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page	e 46	V 133			
V 133	G.S. 122C-80 Crimin	al History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR E (a) Definition As us "provider" applies to a program and any pro developmental disable services that is licens Chapter. (b) Requirement An provider licensed und applicant to fill a posi applicant to fill a posi applicant to fill a posi applicant to have an conditioned on conse criminal history recor the applicant has bee less than five years, f is conditioned on conse criminal history recor national criminal histor five years or more, th on consent to a State check of the applicant employ an applicant criminal history recor section. Except as ot subsection, within five the conditional offer of shall submit a reques Justice under G.S. 1° criminal history recor section or shall submit entity to conduct a St check required by thi					

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336			09	9/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
FRESH N	EW START		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
V 133	Continued From page	e 47	V 133				
	record checks for em covered by Public La Department of Health Criminal Records Ch business days of reco history of the person, and Human Services Unit, shall notify the p information received of the applicant. In no national criminal histor with the provider. Pro- upon request verifica check has been com by this section. A cou appropriate local ordi the Division of Crimin may conduct on beha criminal history recor section without the pu- request to the Depart case, the county shal criminal history recor section within five bu conditional offer of er All criminal history inf provider is confidentia except to the applicat (c) of this section. Fo subsection, the term business regularly er criminal history recor records obtained from (c) Action If an app record check reveals a relevant offense, the	and Human Services, eck Unit. Within five eipt of the national criminal the Department of Health , Criminal Records Check provider as to whether the may affect the employability of case shall the results of the pry record check be shared oviders shall make available tion that a criminal history pleted on any staff covered unty that has adopted an inance and has access to hal Information data bank alf of a provider a State d check required by this rovider having to submit a tment of Justice. In such a II commence with the State d check required by this siness days of the mployment by the provider. formation received by the al and may not be disclosed, int as provided in subsection r purposes of this "private entity" means a hgaged in conducting d checks utilizing public					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09	/29/2020
NAME OF PR	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
RESH NE	W START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN) THE APPROPRIATE	COMPLETI DATE
V 133	Continued From pag	e 48	V 133			
	(1) The level and ser	iousness of the crime.				
	(2) The date of the crime.					
	()	erson at the time of the				
	conviction.					
	(4) The circumstance	es surroundina the				
	commission of the crime, if known.					
	(5) The nexus between the criminal conduct of					
		bb duties of the position to be				
	filled.	·				
	(6) The prison, jail, p	robation, parole,				
	rehabilitation, and en	nployment records of the				
	person since the date	e the crime was committed.				
	(7) The subsequent commission by the person of					
	a relevant offense.					
	The fact of conviction of a relevant offense alone					
	shall not be a bar to employment; however, the					
		e considered by the provider.				
		alifies an applicant after				
		relevant factors, then the				
		e information contained in				
		ecord check that is relevant				
	-	n, but may not provide a copy				
	of the criminal history	y record check to the				
	applicant.					
		A provider and an officer				
		vider that, in good faith,				
	civil liability for:	ction shall be immune from				
		provider to employ an				
		is of information provided in				
		ecord check of the individual.				
		an employee's history of				
		ne employee's criminal				
		is requested and received in				
	compliance with this	•				
	-	e As used in this section,				
		eans a county, state, or				
		ry of conviction or pending				
	indictment of a crime					1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRESH N	EW START		NTINGTON DRIVE NA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVING REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 133	Continued From page	e 49	V 133			
	have responsibility for persons needing mer disabilities, or substa crimes include the cri any of the following A General Statutes: Art Issuing Monetary Sul Endangering Executi Article 6, Homicide; A Sex Offenses; Article Kidnapping and Abdu Injury or Damage by Incendiary Device or and Other Housebrea Other Burnings; Artic Robbery; Article 18, B False Pretenses and Obtaining Property of Fraudulent Use of Cr Article 19B, Financial Act; Article 20, Fraud 26, Offenses Against Decency; Article 36A, F Article 39, Protection Protection of the Fam Intoxication; and Artic Crime. These crimes sale of drugs in violat Controlled Substance 90 of the General Sta offenses such as sale violation of G.S. 18B-	ve and Legislative Officers; Article 7A, Rape and Other 8, Assaults; Article 10, uction; Article 13, Malicious Use of Explosive or Material; Article 14, Burglary akings; Article 15, Arson and le 16, Larceny; Article 17, Embezzlement; Article 19, Cheats; Article 19A, r Services by False or edit Device or Other Means; I Transaction Card Crime s; Article 21, Forgery; Article Public Morality and , Adult Establishments; n; Article 28, Perjury; Article I, Misconduct in Public enses Against the Public Riots and Civil Disorders; of Minors; Article 40, hily; Article 59, Public cle 60, Computer-Related also include possession or tion of the North Carolina es Act, Article 5 of Chapter atutes, and alcohol-related e to underage persons in				

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	(f) Penalty for Furnisl applicant for employr supplies, or otherwise an employment appli criminal history recor shall be guilty of a CI (g) Conditional Employ employ an applicant obtaining the results check regarding the a following requiremen (1) The provider shal prior to obtaining the criminal history recor subsection (b) of this fingerprint cards as re (2) The provider shal criminal history recor business days after t conditional employme 2001-155, s. 1; 2004	ning False Information Any nent who willfully furnishes, e gives false information on cation that is the basis for a d check under this section ass A1 misdemeanor. oyment A provider may conditionally prior to of a criminal history record applicant if both of the ts are met: I not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five he individual begins	V 133			
	failed to ensure crimi completed within five conditional offer of er audited current staff #1/Director/Qualified #2/Executive Directo and 2 of 2 audited for	nd record review, the facility nal background checks were business days of making a mployment affecting 5 of 10 (Licensee Professional #1, Licensee r, Staff #6, Staff #8, Staff #9) rmer staff (Former Staff 's Grandmother and Former				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page 51		V 133			
	revealed: -Hire date not record	Professional #1's record				
	Review on 9/8/20 of Initial Licensure Application with the Division of Health Service Regulation (DHSR) for the facility revealed: -Licensee #1/Director/Qualified Professional #1 was identified on the application for initial licensure dated 12/30/19 and on the license issued on 4/10/20.					
	with DHSR for Sister -Licensee #1/Directo was identified on the	r/Qualified Professional #1				
	Review on 9/8/20 an #2/Executive Directo -Hire date of 8/1/18; -No criminal backgro					
	#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be				
		d 9/9/20 of Staff #8's record				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B WING				
	ROVIDER OR SUPPLIER	MHL036-336	B. WING 09/29				
				, 211 CODE			
RESHINE	EW START	GASTO	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 133	Continued From pag	e 52	V 133				
		d check completed 6/3/20; npleted between 5/20/20 and					
	Review on 9/8/20 and 9/9/20 of Staff #9's record revealed: -Hire date of 12/27/19; -Criminal background check completed 12/20/19; -Agency training completed between 12/3/19 and 12/20/19.						
	Client #2's Grandmo -No hire date recorde -Criminal background	Former Staff #11/Former ther's record revealed: ed; d check completed 12/21/19; npleted in 2018 and 2019.					
	revealed: -Hire date of 6/4/20; -Criminal background	Former Staff #12's record d completed 6/3/20; npleted between 5/21/20 and					
	Director revealed: -Had a pending child neighboring county; -The charge involved -It was a misundersta cleared and the char	d her son; anding and she will be					
	Interview on 9/11/20 -Start date was 5/5/2	with Staff #8 revealed: 20.					
	Interview on 9/2/20 v revealed: -Start date was 5/22/ alth Service Regulation	vith Former Staff #12 /20;					

Division of Health Service Regu STATE FORM

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If continuation sheet 53 of 132

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	MHI 036-336 B. WING		00	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		//25/2020
FRESH NE	EW START					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 133	Continued From pag	e 53	V 133		·	
		l at the facility for hth, was asked to get her a criminal background				
	-Staff were selected which they were fina a bonus; -The hire date in the were officially hired a -Many criminal backy compliance because were removed from t when annual criminal completed on each e -Will complete crimin to training new staff; -Will keep original cr the employee record This deficiency is cro	Professional #1 and ve Director revealed: and received training for ncially compensated through record reflected when they after training was completed; ground checks were out of the original HCPR checks the record and replaced al background checks were employee; nal background checks prior				
V 293		ial Tx. Child/Adol - Scope	V 293			
	children or adolescer free-standing resider intensive, active ther interventions within a shall not be the prim who is not a client of (b) Staff secure mea	atment staff secure facility for nts is one that is a ntial facility that provides rapeutic treatment and a system of care approach. It ary residence of an individual				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 54 of 132

STATEMEN	of Health Service Regun TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09/29/2020	
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
RESH N	EW START		INTINGTON DRIVE NIA, NC 28056			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page 54		V 293			
	 this Section. (c) The population set adolescents who have mental illness, emotion substance-related disco-occurring disordered disabilities. These characterizes and the criteria for int (d) The children or a require the following: (1) removal from community-based rest facilitate treatment; at (2) treatment int (e) Services shall be (1) include indistructure of daily living (2) minimize the related to functional of (3) ensure safe control behaviors incommunication, social (5) support the gaining the skills neee intensive treatment is (f) The residential treatment is (f) The residential treatment is (f) The residential treatment is the conduction of a shall coordinate with the conduction is the conduction of a shall coordinate with the conduction is the conduction of the conduction is the conduction of a shall coordinate with the conduction is the conduction in the conduction is the conduction is the conduction of a shall coordinate with the conduction is the conduction of a shall coordinate with the conduction is the conduction is the conduction is the conduction is the conduction of a shall coordinate with the conduction is the conduction of a shall conduction is the condu	sorders; and may also have rs including developmental nildren or adolescents shall npatient psychiatric services. dolescents served shall im home to a sidential setting in order to and in a staff secure setting. e designed to: ividualized supervision and ag; ne occurrence of behaviors deficits; ety and deescalate out of luding frequent crisis without physical restraint; shild or adolescent in the re functioning in self-control, al and recreational skills; and is child or adolescent in ided to step-down to a less				

	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COMPLET
V 293	Continued From page	e 55	V 293			
	This Rule is not met Based on interview, r	•				
	observation, the facility failed to provide individualized supervision and structure of daily living, minimize the occurrence of behaviors related to functional deficits, ensure safety and					
	acquisition of adaptiv skills needed to step- treatment setting affe	ntrol behaviors, assist in the e functioning and gaining the down to a less intensive cting 5 of 5 audited former ts #1, #2, #3, #4, and #5).				
	Personnel Requireme Based on interview, r observation, the facili	ecord review, and ty failed to ensure staff				
	served affecting 8 of (Licensee #1/Director Licensee #2/Executiv	neet the needs of the clients 10 audited staff members r/Qualified Professional #1, re Director, Associate I, Staff #5, Staff #6, Staff #8,				
	and Staff #9) and 2 o (Former Staff #11/ Fo Grandmother and Fo					
	Competencies of Qua Associate Profession					
	professionals (Licens	udited current qualified ee #1/Director/Qualified				
		d Professional #2) and 1 of 1 ciate professional (Associate				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		MHL036-336	MHL036-336 B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
FRESH NI	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	 V 293 Continued From page 56 skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on interview and record review, 1 of 7 audited current paraprofessionals (Licensee #2/Executive Director) failed to display the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111) Based on interview and record review, the facility failed to ensure assessments were completed prior to the delivery of services and assessments 					
	pertinent social, fami affecting 5 of 5 audite Clients #1, #2, #3, #4 CROSS REFERENC Assessment and Tre Service Plan (V112) Based on interview a failed to develop and	I or admitting diagnosis, and ly, and medical history ed former clients (Former 4, and #5). E: 10A NCAC 27G .0205 atment/Habilitation or nd record review, the facility implement strategies to				
	audited former clients and #4). CROSS REFERENC Medication Requirem	nd record review, the facility received training in				
vision of He	registered nurse, pha	ation completed by a armacist, or other legally cting 2 of 10 audited current				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page 57		V 293			
		essional and Staff #8) and 1 taff (Former Staff #12).				
	Based on interview a failed to ensure the H Registry (HCPR) wa documented prior to affecting 7 of 10 aud #1/Director/Qualified #2/Executive Director Staff #8, and Staff #8 staff (Former Staff # Grandmother and For CROSS REFERENC 131E-256 Health Ca Based on interview a failed to report all all Department and faile	re Personnel Registry (V131) and record review, the facility Health Care Personnel s accessed and the results an offer of employment ited current staff (Licensee Director #1, Licensee r, Staff #4, Staff #5, Staff #6, e) and 2 of 2 audited former 11/Former Client #2's ormer Staff #12). CE: General Statute re Personnel Registry (V132) and record review, the facility egations of abuse to the ed to protect clients from stigation affecting 1 of 10				
	Criminal History Rec Based on interview a failed to ensure crim completed within five conditional offer of e audited current staff #1/Director/Qualified #2/Executive Director and 2 of 2 audited for	and record review, the facility inal background checks were business days of making a mployment affecting 5 of 10				
	CROSS REFERENC Minimum Staffing Re Based on interview,					

TATEMENT OF	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	DER OR SUPPLIER	MHL036-336	DDRESS, CITY, STATE, Z		09	/29/2020	
			NTINGTON DRIVE				
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V 293 Co	ontinued From page	e 58	V 293				
ca we cliu aff #2 CF Re Ba ob fac ho CF Ac Ba fai wit inc by cliu CF Inc an Ba fai ou CF Inc an Ba fai (Inc	re staff when one, ere present and fail ents when they we fecting 5 of 5 forme are and fail ents when they we fecting 5 of 5 forme are and the state are and the state are and the state are and the state are and a state are	ity failed to ensure consultation at least four a licensed professional. E: General Statute 122C-62 24-Hour Facility (V364) nd record review, the facility munication and consultation lian or the agency or al custody without restriction g 5 of 5 audited former ts #1, #2, #3, #4, and #5). E: 10A NCAC 27G .0603 equirements for Category A S6) nd record review, the facility cidents were reported as y and procedure. E: 10A NCAC 27G .0604 equirements for Category A					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page 59		V 293			
	Least Restrictive Alte Based on interview a failed to ensure a res affecting 5 of 5 audite Clients #1, #2, #3, #4 CROSS REFERENC Training on Alternativ Interventions (V536) Based on interview a failed to ensure staff	 and record review, the facility appectful environment and former clients (Former and #5). and				
	Training in Seclusion Isolation Time-Out (V Based on interview a failed to ensure staff physical restraint and 1 of 10 audited staff i	nd record review, the facility were trained in seclusion, d isolation time-out affecting members (Staff #6). E: 10A NCAC 27F .0104				
	Based on interview a failed to protect clien	nd record review, the facility ts' personal possessions ed former clients (Former 4).				
	revealed: -Former clients were other's rooms until " . raping [Former Client	with Former Client #1 allowed to play in each [Former Client #4] started t #2];" nd #4 both had their clothes				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			5.14/10				
		MHL036-336			09	/29/2020	
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RESH NE	W START		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From page	e 60	V 293				
	."						
	-Former Client #4 put Former Client #2 up in the						
	air and threw Former	Client #2 onto the bed;					
		nd #4 had their clothes on					
		ch other's "private parts"					
	while Former Client #						
		t the room to tell Staff #6; iving room with another staff.					
		-					
	Interview on 8/12/20 revealed:	with Former Client #2					
		t2, and #3 were in the room					
		ormer Client #4 snuck into					
	the room;						
	-Former Client #4 be	gan "acting like a boy;" nt Former Client #2 over the					
	bed; -Former Client #4 wa	as behind Former Client #2					
	and Former Client #4 would flip her over;	told Former Client #2 she					
		.did inappropriate stuff she					
	had no business doir	ngshe grabbed my leg					
	she was trying to h	ump me;"					
	-Denied any fondling	,					
		d Former Client #4 to stop					
	but Former Client #4	•					
	were in the living roo	f in the house but the staff m.					
	Interview on 9/3/20 w	vith Former Client #3					
	revealed:						
		Client #4 put Former Client					
	#2 in a sexual position	-					
	-Both Former Clients clothed;	#2 and #4 were fully					
	,	d Former Client #4 to stop;					
		r staff were in the living room					
	"minding their own	i business"					
	Interview on 8/13/20	with Former Client #4					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
				A. BUILDING:			
		MHL036-336	B. WING		09	0/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
RESH NE	W START		NTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From page	e 61	V 293				
	allowed out of their b would play in each of in the living room; -On 8/3/20, the forme bedroom; -Staff #6 was in the li was present but she second staff was but Staff #8. Both staff w -Former Client #4 tol would help her do a b -Former Client #4 tol would help her do a b -Former Client #4 tol would help her do a b -Former Client #4 do sexual. Review on 9/28/20 of dated 9/29/20 signed #1/Director/Qualified "What immediate act ensure the safety of the have any residents of facility. That being so the following actions consumers in its care care staff return to the V108: Fresh New Sta with all requirements including: a. Enforcing the reference	d Former Client #2 she headstand on the bed; shed Former Client #2 over a "humping action;" d not mean for it to seem f the first Plan of Protection I by Licensee Professional #1 revealed: ion will the facility take to the consumers in your care? ew Start (facility) does not r direct care staff in this aid, Fresh New Start will take to ensure the safety of e when residents and direct					
		aintained for each individual the training, experience and					

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
				A. BUILDING:		
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RESH NI	EW START		NTINGTON DRIVE NIA, NC 28056			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 62	V 293			
	 verification of licensu certification. d. Employee training provided and, at a mit following: general organization general organization training on client delineated in 10A NC 10A NCAC 26B; training to meet the health/developmentain needs of the client as treatment/habilitation training in infect bloodborne pathogen Specifically, the agen returning staff to have and to retake competed D (1-4) above. All per to ensure compliance V109: Fresh New Starequirements of 10A ensuring the competed Professional will recet trainer within the 23 of 1. technical knowle cultural awarenee analytical skills; decision-making interpersonal skii communication s clinical skills. 	ational orientation; rights and confidentiality as CAC 27C, 27D, 27E, 27F and the mh/dd/sa (mental I disability/substance abuse) specified in the plan; and ious diseases and as. noy will require all new and e new background checks tency-based training in Item ersonnel files will be audited a with this standard. art will comply with all NCAC 27G .0203 including ency of the Qualified cally, the Qualified tays about: edge; ess; ; Ils; skills; and art will comply with all NCAC 27G .0204 including ency of the Para				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
				A. BUILDING:		
		MHL036-336	B. WING		09	0/29/2020
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	trainer within the 30 of 8. technical knowle 9. cultural awarene 10. analytical skills; 11. decision-making 12. interpersonal ski 13. communication s 14. clinical skills. V111&V112: Fresh N requirements of 10A a. Enforcing the re- assessment shall be prior to the delivery of not be limited to: 1. the client's prese 2. the client's need 3. a provisional or established diagnosis of 4. admission, exce	ceive training by a qualified days of hire or return to work: edge; ess; ; ;; ills; skills; and ew Start will comply with all NCAC 27G .0205 including: quirement that an admission completed for all consumers of services, that includes, but enting problem; s and strengths; admitting diagnosis with an s determined within 30 days pt that a client admitted to a r 24-hour medical program	V 293			
	 a pertinent social and evaluations or as psychiatric, substance vocational, as appropriate to the b. Enforcing the reserved Plastarting services that address the client's p 					
		art will comply with all NCAC 271g .0209 including				

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
				A. BUILDING:			
		MHL036-336	B. WING		09/29/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE		ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From pag	e 64	V 293				
	Continued From page 64 ensuring all direct care staff have documented training by qualified trainer in the following topics: a. Medication dispensing: Medication packaging and labeling b. Medication administration c. Medication disposal d. Medication Storage e. Medication review f. Medication education g. Medication education g. Medication errors In addition, the agency will update its policy and procedure to ensure its procedures include all required elements. All new and returning staff will be trained in its requirements by a medical professional, e.g. a registered nurse, prior to dealing with medications. In addition, the agency will contract with a medical professional to oversee its medication practices. The medical professional will conduct self-audits of medication related record at least monthly. The result of the self-audits will be kept on file.						
	requirements of GS requirement that all s Personnel Registry of Specifically, the ager Personnel Registry of returning staff upon h thereafter. Personnel files will b	ncy will conduct Health Care					
	requirements of GS requirement that all s check on file. Specifically, the ager record checks on all	art will comply with all 122C-80 including the staff have a criminal record ncy will conduct state criminal new and returning staff prior annually thereafter. Any staff					

Division of Health Service Regul STATE FORM

6899

If continuation sheet 65 of 132

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		MHL036-336	B. WING		09	9/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
RESH NI	EW START		JNTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		DID SUMMARY STATEMENT OF DEFICIENCIES ID PROV FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH O		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 65	V 293				
	past 5 consecutive ye Bureau of Investigation The agency will follow 122C-80(c-e) when n decisions. Personnel files will be basis to ensure comp V296: Fresh New Star requirements of 10A Enforcing the require a. A qualified profe- telephone or page. A to reach the facility w b. The minimum nur required when childred present and awake is 1. two direct care s two, three or four chil The agency will interp to include a requirem	ssional shall be available by direct care staff will be able rithin 30 minutes at all times unber of direct care staff en or adolescents are as follows: taff shall be present for one,					
	requirements of 10A a. Enforcing the rea associate level profes (Licensed Clinical So Professional Counse Marriage and Family Associate, Psycholog present on site a min Specifically: 1. The licensed pro- out at the facility. The kept in the record. 2. The licensed pro-	art will comply with all NCAC 27G .1705 including: quirement that a licensed or ssional, e.g. LCSW pcial Worker), LPC (Licensed					

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 66	V 293			
V 293	 Continued From page 66 supervision of the qualified professional specified in Rule .1702; ii. Individual, group or family therapy services; or iii. Involvement in child or adolescent specific treatment plans or overall program issues. b. As permitted by NC DMA CCP 8D2- "Group therapy or activity time may be included as total time per beneficiary (i.e., if there are six members in a group for 90 minutes, this may be counted as 90 minutes per beneficiary)." 					
	requirements of GS (including GS 122C-6 agency to enforce the minor client who is re- habilitation in a 24-be Make and receive co- In extraordinary circu- allows this right to be of § 122C-62(e) are no that " No right enume (d) of this section ma- except by the qualifier for the formulation of habilitation plan. A we placed in the client's detailed reason for the shall be reasonable at treatment or habilitat effective for a period evaluation of each re- by the qualified profe days, at which time the removed. Each evaluation of the start of the formulation of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start o	bur facility has the right to: (1) Infidential telephone calls." Imstances § 122C-62(b) e curtailed if the requirements met. § 122C-62(e) states erated in subsections (b) or y be limited or restricted ed professional responsible the client's treatment or ritten statement shall be record that indicates the he restriction. The restriction and related to the client's ion needs. A restriction is not to exceed 30 days. An estriction shall be conducted essional at least every seven he restriction may be lation of a restriction shall be ient's record. Restrictions on				

	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
				A. BUILDING:			
		MHL036-336	B. WING		09	0/29/2020	
AME OF PROV	/IDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
RESH NEW	START		NTINGTON DRIVE				
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V 293 C	ontinued From page	e 67	V 293				
re w Tr CC T CC a e V re a re R M a (I I r a b fil c. in a d su re C T C C a e V re a re C T C C a e V re C T C C A C T C C C a e V T C C C A C T C C C A C C T C C A C C T C C A C C T C C C A C C T C C C A C C C C	enewal of the restrict ith this requirement o provide an extra la consumer's right any nodification shall be gency's Clients Right committee and the le he agency's Policy a consumer rights, pers- clients Rights Behav round this matter sh nsure clarity on this 366: : Fresh New S equirements of 10A . Ensuring that all eported to DHSR (D tegulation) and the L lanagement Entity/M is required by the pro- Department of Healt incident Reporting Sy and 10A NCAC 27g . The agency will e for inspection for . New hires and re- nually thereafter. . The agency will elf-audits to ensure including cross walking otes to incident report 367 Fresh New Sta equirements of 10A	ayer of ensuring the such Person-Centered Plan approved in writing by the nts Behavioral Intervention egally responsible person. and Procedure around son-centered planning, and ioral Intervention Committee hall be reviewed/updated to matter. tart will comply with all NCAC 27g .0603 including: Level II and III incidents are ivision of Health Service LME/MCO (Local Managed Care Organization) evailing NC DHHS h and Human Services) ystem (IRIS) within the IRIS 0604 stipulated timeframes. keep all incident reports on governmental authorities. eturning staff will be retrained prior to hire/return and conduct at least quarterly this standard is met ng Level I,II, & III progress ports.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
				A. BUILDING:		
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
FRESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 68	V 293			
	requirements of 10A a. The agency will Alternatives To Restr that all staff must con as defined in NCAC 2 will a curriculum appr DMH/IDD/SAS on the b. The agency will returning staff have v To Restrictive Interver before working and a c. The agency will self-audits to ensure V537: Fresh New Sta requirements of NCA Cross reference to re V513: Fresh New Sta requirements of 10A a. Ensuring that all services/supports that respectful environme a. using the least re appropriate settings a b. promoting coping are alternatives to inj others; c. providing choice the clients served/sup d. sharing of contro client/legally respons e. The use of a res	NCAC 27E .0107 including: choose one Training On ictive Interventions curricula nplete by a qualified trainer 27E .0108 . The curriculum roved by the NC eir list of approved curricula. ensure all newly hired and ralid Training On Alternatives entions certificate on file innually thereafter. conduct at least quarterly this standard is met. art will comply with all C 27E .0108. esponse to V536. art will comply with all NCAC 27E .0101 including; staff will provide at promote a safe and nt. These include: estrictive and most and methods; g and engagement skills that urious behavior to self or s of activities meaningful to poprted; and ol over decisions with the ible person and staff. trictive intervention to reduce a behavior shall				
	f. designed to insu and after the interverg. using the interve	re dignity and respect during ntion. These include: ention as a last resort; and tervention only by people				

Division of Health S STATE FORM

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
				A. BUILDING:		
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From page	e 69	V 293			
	V536 and V537					
	V536 and V537 V541: Fresh New Start will comply with all requirements of 10A NCAC 27F .0104 including making reasonable efforts to ensure consumers' personal clothing and possessions are safe from theft, damage, destruction, loss, and misplacement. This will include, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires. To facilitate this the agency will take an inventory of all clothes and possessions upon admission, discharge and on a case by case basis prior to and after a home visit. In the event a consumer is discharged and leaves a possession behind the item will mail to the legally responsible person within 7 days of discovery.					
	happens. As noted in the prear not have any residen facility. To ensure con Protection (POP) and Correction (POC) the actions noted in the a In addition, the agend actions to make sure subsequent POC are a. Contract with a C Care Auditor for three 1. Conduct quarter sure compliance with subsequent POC. The record.	implemented. Certified Forensic Health months to: Iy self-audits of the agency to				

STATE FORM

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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Continued From page	e 70	V 293				
 Conduct training returning staff about subsequent POC. The live online. The initial available to playback annual retraining. Conduct compet Qualified Professional live or live online. The recorded and availab hires and annual retrr b. The agency will facility until such time 	with newly hired and this POP and any re initial training will be live or training will be recorded and for future staff hires and rency-based training with the al. The initial training will be e initial training will be le to playback for future staff aining. not place residents in the e as all the actions in the					
Protection dated 9/29	9/20 signed by Licensee					
have any residents of facility. That being so the following actions consumers in its care	r direct care staff in this aid, Fresh New Start will take to ensure the safety of when residents and direct					
with all requirements including: e. Enforcing the rea applicants for employ conviction. f. A file shall be ma	of 10A NCAC 27G .0202 quirement that that all ment disclose any criminal aintained for each individual					
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page Intervention Committ 4. Conduct training returning staff about subsequent POC. The live online. The initial available to playback annual retraining. 5. Conduct compete Qualified Professional live or live online. The recorded and available hires and annual retrr b. The agency will facility until such time POP are fully implem Review on 9/29/20 of Protection dated 9/25 #1/Director/Qualified "What immediate act ensure the safety of the At this time, Fresh Ne have any residents of facility. That being sat the following actions consumers in its care care staff return to the V108: Fresh New Stat with all requirements including: e. Enforcing the real applicants for employ conviction. f. A file shall be matical POP and State	IDENTIFICATION NUMBER: INHL036-336 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 70 Intervention Committee 4. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live online. The initial training will be live or live online. The initial training will be recorded and available to playback for future staff hires and annual retraining. 5. Conduct competency-based training will be live or live online. The initial training will be recorded and available to playback for future staff hires and annual retraining. b. The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented." Review on 9/29/20 of the second Plan of Protection dated 9/29/20 signed by Licensee #1/Director/Qualified Professional #1 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? At this time, Fresh New Start (Facility) does not have any residents or direct care staff in this facility. That being said, Fresh New Start will take the following actions to ensure the safety of consumers in its care when residents and direct care staff return to the facility. V108: Fresh New Start (the "agency") will comply with all requirements of 10A NCAC 27G .0202 including: e. Enforcing the requirement that that all applicants for employment disclose any criminal conviction. <td>PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL036-336 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 70 V 293 Intervention Committee V 293 4. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live online. The initial training will be recorded and available to playback for future staff hires and annual retraining. V 293 5. Conduct competency-based training with the Qualified Professional. The initial training will be live or live online. The initial training will be recorded and available to playback for future staff hires and annual retraining. Note that the actions in the POP are fully implemented." 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WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SW START 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY WINT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 70 V 293 Intervention Committee V 293 Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live online. The initial training will be recorded and available to playback for future staff hires and annual retraining. V 293 C. Conduct competency-based training will be live or live online. The initial training will be recorded and available to playback for future staff hires and annual retraining. Not agency will not place residents in the facility until such time as all the actions in the POP are fully implemented." 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			A. BUILDING:					
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NAME OF PR	OVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE				
RESH NE	W START		INTINGTON DRIVE NIA, NC 28056					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 71	V 293					
	verification of licensu certification. h. Employee trainin provided and, at a m following: (1) general organiza (2) training on client delineated in 10A NC (3) 10A NCAC 26B; (4) training to meet Health/Development: Abuse) needs of the treatment/habilitation (5) training in infect bloodborne pathoger Specifically, the ager returning staff to hav prior to starting work competency-based th prior to starting work audited to ensure coi (*see additional infor regarding training da V109: Brighter Dayz will comply with all re 27G .0203 including the Qualified Profess	ng programs shall be inimum, shall consist of the ational orientation; trights and confidentiality as CAC 27C, 27D, 27E, 27F and the mh/dd/sa (Mental al Disability/Substance client as specified in the plan; and tious diseases and ns. ncy will require all new and e new background checks * and to retake raining in Item D (1-4) above . All personnel files will be mpliance with this standard. mation on last page tes) (Licensee/Sister Facility A) equirements of 10A NCAC ensuring the competency of sional. Specifically, the al will receive training by a 0/18/20: edge; ess; i; ills; skills; and						
	th Service Regulation							

STATE FORM

A. BUILDING:	09/29/2020 (X5) COMPLET DATE
VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FRESH NEW START GASTONIA, NC 28056 (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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 293 Continued From page 72 V 293 V 293 Continued From page 72 V 293 Y 293 Continued From page 72 V 293 V 293 Continued From page 72 V 293 Z requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, newly hired and returning Para Professionals will receive training by a qualified trainer prior to starting work. 22. technical knowledge; 23. cultural awareness; 24. analytical skills; 25. decision-making; 26. interpersonal skills; and	(X5) COMPLET
HERESH NEW STARTHAG0 HUNTINGTON DRIVE GASTONIA, NC 28056(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)V 293Continued From page 72V 293requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, newly hired and returning Para Professionals will receive training by a qualified trainer prior to starting work. 22. technical knowledge; 23. cultural awareness; 24. analytical skills; 25. decision-making; 26. interpersonal skills; 27. communication skills; andV 293	COMPLET
CASTONIA, NC 28056 (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) V 293 Continued From page 72 V 293 requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, newly hired and returning Para Professionals will receive training by a qualified trainer prior to starting work. 22. technical knowledge; 23. cultural awareness; 24. analytical skills; 25. decision-making; 26. interpersonal skills; 27. communication skills; and V 293	COMPLET
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)V 293Continued From page 72V 293requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, newly hired and returning Para Professionals will receive training by a qualified trainer prior to starting work. 22. technical knowledge; 23. cultural awareness; 24. analytical skills; 25. decision-making; 26. interpersonal skills; 27. communication skills; andV 293	COMPLET
requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, newly hired and returning Para Professionals will receive training by a qualified trainer prior to starting work. 22. technical knowledge; 23. cultural awareness; 24. analytical skills; 25. decision-making; 26. interpersonal skills; 27. communication skills; and	
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 V111&V112: Fresh New Start will comply with all requirements of 10A NCAC 27G .0205 including: b. Enforcing the requirement that an admission assessment shall be completed for all consumers prior to the delivery of services, that includes, but not be limited to: 1. the client's presenting problem; 2. the client's needs and strengths; 3. a provisional or admitting diagnosis with an established diagnosis determined within 30 days of 4. admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; 5. a pertinent social, family, and medical history; and 6. evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as 7. appropriate to the client's need c. Enforcing the requirement that a Person-Centered Plan be developed prior to starting services that includes strategies to address the client's presenting problem. The plan 	

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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V 293	Continued From page	e 73	V 293			
	ensuring newly hired documented training following topics prior h. Medication dispe- and labeling i. Medication admit j. Medication admit j. Medication dispe- k. Medication Stora l. Medication revie m. Medication error In addition, the agen- procedure to ensure required elements. A be trained in its requi professional, e.g. a re- dealing with medication professional will contract related record at lease self-audits will be kep V131: Fresh New Star requirements of GS	NCAC 271g .0209 including or returning staff have by qualified trainer in the to working: ensing: Medication packaging inistration osal age w ration s cy will update its policy and its procedures include all II new and returning staff will irements by a medical egistered nurse, prior to ions. In addition, the agency edical professional to on practices. The medical duct self-audits of medication at monthly. The result of the ot on file.				
	Personnel Registry c Specifically, the ager Personnel Registry c returning staff upon h thereafter.	ncy will conduct Health Care heck on all new and hire/return and annually				
	basis to ensure comp V133: Fresh New Sta	e self-audited on a quarterly bliance with this standard. art will comply with all 122C-80 including the				

STATE FORM

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL036-336	B. WING		09)/29/2020
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		4460 HU	INTINGTON DRIVE			
FRESH NE	W START	GASTO	NIA, NC 28056			
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V 293	Continued From pag	e 74	V 293			
	check on file.					
		ncy will conduct state criminal				
		new and returning staff prior				
		annually thereafter. Any staff				
	•	NC for the past 5 consecutive				
	years will have a SB	I criminal record check. The				
	agency will follow the					
	· · ·	making hiring/retention				
	decisions.					
		e self-audited on a quarterly				
	basis to ensure com	pliance with this standard.				
	V296. Fresh New St	art will comply with all				
		NCAC 27G .1704 including:				
	Enforcing the require					
	÷ .	ssional shall be available by				
	telephone or page. A	direct care staff will be able				
	to reach the facility w	vithin 30 minutes at all times				
		umber of direct care staff				
		en or adolescents are				
	present and awake is					
		staff shall be present for one,				
		Idren or adolescents;				
		pret 10A NCAC 27G .1704(b)				
		nent that if a (singular) community with staff that two				
	staff shall be present	3				
	V297: Fresh New Sta	art will comply with all				
		NCAC 27G .1705 including:				
		quirement that a licensed or				
	associate level profe					
		cial Worker), LPC (Licensed				
		elor), LMFT (Licensed				
		Therapist), Psychological				
		gist, Psychiatrist will be nimum of 4 hours per week.				
	Specifically:	innum of 4 nours per week.				
		ofessional shall sign in and				
	out at the facility. The					1

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
FRESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	e 75	V 293			
	kept in the record. 2. The licensed pro- i. Documented mo- supervision of the qui in Rule .1702; ii. Individual, group or iii. Involvement in or treatment plans or ov c. As permitted by therapy or activity tim time per beneficiary of in a group for 90 min 90 minutes per bene V364: Fresh New Starequirements of GS (including GS 122C-6 agency to enforce the minor client who is re- habilitation in a 24-ho Make and receive coo In extraordinary circu- allows this right to be of § 122C-62(e) are to that " No right enume (d) of this section ma- except by the qualifier for the formulation of	ofessional will provide: onthly formal clinical alified professional specified o or family therapy services; whild or adolescent specific verall program issues. NC DMA CCP 8D2- "Group ne may be included as total (i.e., if there are six members utes, this may be counted as ficiary)." art will comply with all (General Statute) 122C-62 (2(d)(1) that requires the e requirement that "each				
	detailed reason for the shall be reasonable a treatment or habilitat	record that indicates the ne restriction. The restriction and related to the client's ion needs. A restriction is				
	evaluation of each re by the qualified profe days, at which time t	not to exceed 30 days. An estriction shall be conducted essional at least every seven he restriction may be uation of a restriction shall be				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
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IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
RESH NE	EW START		NTINGTON DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From page	e 76	V 293				
	rights may be renewe statement entered by the client's record that	the qualified professional in at states the reason for the tion." The agency will comply					
	modification shall be agency's Clients Righ Committee and the le The agency's Policy a consumer rights, pers Clients Rights Behav	such Person-Centered Plan approved in writing by the ots Behavioral Intervention egally responsible person. and Procedure around son-centered planning, and ioral Intervention Committee all be reviewed/updated to					
V366: : Free requiremen e. Ensurin reported to by the preva Department Incident Re and 10A NC f. The ag file for inspe g. New hi in incident r annually the h. The ag self-audits t	requirements of 10A e. Ensuring that all reported to DHSR an by the prevailing NC Department of Health Incident Reporting Sy and 10A NCAC 27g. f. The agency will file for inspection for g. New hires and re in incident reporting p annually thereafter. h. The agency will self-audits to ensure	ng Level I,II, & III progress					
	V367 Fresh New Sta requirements of 10A	rt will comply with all					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
RESH NI	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 293	Continued From page	e 77	V 293			
	requirements of 10A d. The agency will of Alternatives To Restri- that all staff must com as defined in NCAC 2 will a curriculum appr DMH/IDD/SAS (Depa Health/Intellectual Dep Disability/Substance of approved curricula e. The agency will of returning staff have v To Restrictive Interver before prior to workin f. The agency will of self-audits to ensure V537: Fresh New Sta requirements of NCA Cross reference to re V513: Fresh New Sta requirements of 10A c. Ensuring that all services/supports that respectful environme a. using the least re appropriate settings a b. promoting coping are alternatives to inj others; c. providing choice the clients served/sup d. sharing of contro client/legally respons e. The use of a res	artment of Mental evelopmental Abuse Services) on their list a. ensure all newly hired and valid Training On Alternatives entions certificate on file and annually thereafter. conduct at least quarterly this standard is met. art will comply with all AC 27E .0108. esponse to V536. art will comply with all NCAC 27E .0101 including; staff will provide at promote a safe and ant. These include: estrictive and most and methods; g and engagement skills that urious behavior to self or s of activities meaningful to				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MUI 026 226	MHL036-336 B. WING		09/29/202	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		09	/29/2020
			NTINGTON DRIVE	,		
RESH NI	EW START	GASTON	NA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 293	Continued From pag	je 78	V 293			
	and after the interve g. using the interve d. employing the in trained in its use. Cr V536 and V537 V541: Fresh New St requirements of 10A making reasonable of personal clothing an theft, damage, destr misplacement. This to, assisting the clier maintaining an inver possessions if the cl person desires. To fa take an inventory of upon admission, disc case basis prior to a In the event a consu a possession behind legally responsible p	will include, but is not limited				
	happens. As noted in the prea not have any resider facility. To ensure co Protection (POP) an Correction (POC) th actions noted in the In addition, the agen actions to make sure subsequent POC are c. Contract with a Care Auditor for thre	e implemented. Certified Forensic Health				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-336 B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		08	9/29/2020
			INTINGTON DRIVE	,		
FRESH NE	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	e 79	V 293			
	subsequent POC. T record. 7. Consult with lea matters. 8. Consult with Clie Intervention Committ 9. Conduct training returning staff about subsequent POC pri- training will be live of training will be live of training will be record for future staff hires a 10. Conduct compet Qualified Professional training will be live of training will be live of training will be record for future staff hires a d. The agency will facility until such time POP are fully implem Additional Informatio Regarding training da Professional will be t 10/18/20. However, off all direct care staff	he self-audits will be in the dership about compliance ent Rights Behavioral tee g with newly hired and this POP and any or to staff working. The initial r live online. The initial ded and available to playback and annual retraining. tency-based training with the al by 10/18/20. The initial r live online. The initial ded and available to playback and annual retraining. not place residents in the e as all the actions in the nented.				
	staff will be trained o receive all required to Regarding Certified I [Consultant] is the Co	ther than to say that they will raining PRIOR to working. Healthcare Auditor- ertified Internal Forensic				
	American Institute of (certification is attach Certified Internal For has a Masters in Hur and thirty plus years	Consultant] is certified by the Healthcare Compliance ned). [Consultant] is a ensic Healthcare Auditor, mans Services Administration of experience in behavioral tate and private provider				

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	je 80	V 293			
		twenty years of C-Level (high th quality assurance and				
	surveyor for the Acce Health Care and con accreditation standa regional performance program and the Not and Community Bas	d behavioral healthcare reditation Commission for isulted in the development of rds. He has overseen the e of a class action lawsuit rth Carolina Medicaid Home ed Waiver. He has been an a multi-state provider agency array of services.				
	Illness Management Specialist, and Esse trainer. He is a forme [College] in their Man person-centered plan	son-Centered Thinking, and Recovery, Peer Support ntial Lifestyle Planning er Field Faculty Adviser with ster's program for nning and systems change. ''s website: [website address].				
		contract expires the al will assume the duties of ce with this POPC and any				
	10/18/20. However, off all direct care star rehire staff. Therefor concrete date Assoc staff will be trained o	ates- The Qualified trained by [Consultant] by at present the facility has laid ff and will need to hire or re, it is not possible to give a iate and Para Professional other than to say that they will rraining PRIOR to working."				
	diagnosed with Disru Disorder and Attentio	s 11 years old and was uptive Mood Dysregulation on Deficit Hyperactivity a history of assault, property				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING:		OATE SURVEY OMPLETED
	MUL 000 000	MHL036-336 B. WING		00/00/0000
NAME OF PROVIDER OR SUPPL		T ADDRESS, CITY, STATE, ZIP CC		09/29/2020
		HUNTINGTON DRIVE		
FRESH NEW START		ONIA, NC 28056		
PREFIX (EACH DE	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
V 293 Continued Fro	m page 81	V 293		
sexualized act possible sexua to 5 behaviora #2 was 9 years Traumatic Stree Hyperactivity I property destru- sexually moles Former Client diagnosed with Disorder, Post Oppositional ID She had a hist car with unkno- behaviors, and 13 years old at Oppositional ID Trauma. She destruction, ph behaviors, sex allegations of a years old and Stress Disorder Disorder, and history of ange commands. The facility did assessments i needs and stree diagnosis, and medical history #5. There was completed for the facility did individualized functional defor	ge, poor hygiene, discussing wity while at day camp and dized behaviors in the past, with 4 outbursts weekly. Former Client is old and was diagnosed with Post ss Disorder and Attention Deficit Disorder. She had a history of action, self-harm, and had been ted at the age of 5 or 6 years old. #3 was 13 years old and was n Attention Deficit Hyperactivity Traumatic Stress Disorder, efiant Disorder, and Depression. ory of running away, getting in the wn males, increased sexual aggression. Former Client #4 was nd was diagnosed with efiant Disorder and Unspecified had a history of property ysical assault, sexualized ual abuse/rape, and false abuse. Former Client #5 was 10 was diagnosed with Post Traumatic rr, Disruptive Mood Dysregulation Unspecified Trauma. She had a rr, aggression, and auditory not complete admission nclusive of presenting problem, engths, provisional or admitting pertinent social, family, and r for Former Client #2. Furthermore, not develop and implement reatment plans reflecting the cits of the clients. There were no egies in place when clients ran			

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE		
FRESH NE	EW START		JNTINGTON DRIVE NIA, NC 28056			
(X4) ID SUMMARY				PROVIDER'S PLAN C	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	COMPLETI
V 293	Continued From pag	e 82	V 293			
	behavior, or displaye	ed sexually inappropriate				
		Clients #1, #3, and #4				
	attended various sur	nmer day camps but there				
		rategies to reflect the use of				
		er Clients #1, #3, and #4 all				
		cement at the day camps				
	due to their assaultiv	e or sexualized behaviors.				
	The facility did not e	nsure proper training for the				
	•	ds of the clients. Staff				
		man sexuality and sexually				
		s. Medication administration				
	training for three stat					
	questionable. One s	staff member had never been				
		s to Restrictive Intervention				
		nt, Seclusion, and Isolation				
		are Personnel Registry and				
	•	checks were not completed				
	not protected after a	more, Former Client #3 was				
	committed by Staff #	-				
	The facility was not o	operated in a respectful				
		profanity and derogatory				
	terms toward the form	mer clients. Additionally,				
	Staff #8 placed her h	and around the throat of				
		he facility did not allow clients				
		e calls with their legal				
		ere inconsistencies regarding				
	the services of the Li					
	Professional/Qualifie					
	ratios to ensure supe	ility did not maintain staffing				
	resulting in multiple t					
		ekly. Former Client #2, a				
	5	estation at an early age, was				
		y Former Client #4 during				
		m. Former Clients #1 and				
		own history of sexually				
	inappropriate behavi					

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 83	V 293			
	were in the common a not providing proper s reporting was not cor personal property wa to them immediately a Licensee #1/Director/ Licensee #2/Executiv Professional/Qualified Associate Profession necessary oversight r receiving the care red This deficiency const violation for serious h	npleted. Former clients' s not protected and returned at discharge. /Qualified Professional #1, ve Director, Licensed d Professional #2 and al failed to provide the resulting in clients not quired.				
V 296	Staffing 10A NCAC 27G .170 REQUIREMENTS	al Tx. Child/Adol - Min. 4 MINIMUM STAFFING ssional shall be available by	V 296			
	telephone or page. A able to reach the faci times. (b) The minimum nur required when childre present and awake is (1) two direct c one, two, three or fou (2) three direct for five, six, seven or adolescents; and (3) four direct c nine, ten, eleven or tw adolescents.	A direct care staff shall be lity within 30 minutes at all mber of direct care staff en or adolescents are as follows: tare staff shall be present for ir children or adolescents; care staff shall be present eight children or care staff shall be present for				

Division of Health Service Regulatio STATE FORM

6899

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If continuation sheet 84 of 132

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	MUI 026 226				
ROVIDER OR SUPPLIER			, ZIP CODE	08	0/29/2020
	4460 HU	INTINGTON DRIVE			
	GASTO	NIA, NC 28056			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
Continued From page	e 84	V 296			
follows: (1) two direct of and one shall be awa children or adolescer (2) two direct of and both shall be aw children or adolescer (3) three direct of which two shall be asleep for nine, ten, of adolescents. (d) In addition to the care staff set forth in Rule, more direct car the facility based on individual needs as so plan. (e) Each facility shall supervision of childred are away from the fac- child or adolescent's	care staff shall be present ake for one through four nts; care staff shall be present ake for five through eight nts; and t care staff shall be present awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this re staff shall be required in the child or adolescent's specified in the treatment I be responsible for ensuring en or adolescents when they cility in accordance with the individual strengths and				
Based on interview, r observation, the facil care staff when one, were present and fail clients when they we affecting 5 of 5 forme	record review, and ity failed to ensure two direct two, three, or four clients led to ensure supervision of re away from the facility er clients (Former Clients #1,				
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag during child or adoles follows: (1) two direct of and one shall be awa children or adolescer (2) two direct of and both shall be awa children or adolescer (2) two direct of and both shall be awa children or adolescer (3) three direct of which two shall be asleep for nine, ten, or adolescents. (d) In addition to the care staff set forth in Rule, more direct care the facility based on individual needs as as plan. (e) Each facility shall supervision of childred are away from the fa child or adolescent's needs as specified in This Rule is not met Based on interview, for observation, the facili care staff when one, were present and fail clients when they we affecting 5 of 5 forme	OF CORRECTION IDENTIFICATION NUMBER: MHL036-336 ROVIDER OR SUPPLIER STREET A EW START 4460 HL GASTOI GASTOI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 84 during child or adolescent sleep hours is as follows: (1) (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL038-336 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 84 V 296 during child or adolescent sleep hours is as follows: V (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; and V (3) three direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) (4) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be present individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescent's individual needs as specified in the treatment plan. (e) Each facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure two direct care staff when one, two, three, or four clients were present and failed to ensure supervision of clients when they were away from the facility affecting 5 of 5 former clients (Former Clients #1,	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: MHL036-336 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SW START 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY WITS BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN (RECULATORY OR USC IDENTIFYING INFORMATION) Continued From page 84 V 296 during child or adolescent sleep hours is as follows: V (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; and (3) V (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (a) (b) In addition to the minimum number of direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescent's individual strengths and needs as specified in the treatment plan. (f) This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure two direct care staff when one, two, three, or four clients were present and failed to ensure two direct care staff when one, two, three, or four clients were present and failed to ensure two direct care staff when one, two, three, or four clients were present and failed to ensure two direct care staff when one, two, three, or four clients were present and failed to ensure tw	OP CORRECTION IDENTIFICATION NUMBER: A BUILDING:

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NI	EW START		INTINGTON DRIVE NIA, NC 28056			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 296	Continued From page	e 85	V 296			
	Disorder and Attention Disorder; -11 years old; -History of assault, pup poor hygiene, discuss at day camp and posis the past, with 4 to 5 to Review on 8/11/20, 8 Former Client #2's re -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Posis and Attention Deficit -9 years old; -History of property do Review on 8/11/20, 8 Former Client #3's re -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atten Disorder, Post Traum Oppositional Defiant -13 years old; -History of running av unknown males, increating aggression. Review on 8/11/20, 8 Former Client #4's re -Admitted 4/24/20; -Discharged 8/6/20;	uptive Mood Dysregulation n Deficit Hyperactivity roperty destruction, rage, sing sexualized activity while sible sexualized behaviors in behavioral outbursts weekly. /12/20 and 8/18/20 of cord revealed: t Traumatic Stress Disorder Hyperactivity Disorder; estruction and self-harm. /12/20 and 8/18/20 of cord revealed: htion Deficit Hyperactivity hatic Stress Disorder, Disorder, Depression; vay, getting in the car with eased sexual behaviors, and /12/20 and 8/18/20 of cord revealed:				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336	B. WING		09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RESH NE	EW START		INTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 296	-History of property destruction, physical assault, sexualized behaviors, sexual abuse/rape, and false allegations of abuse.		V 296				
	Former Client #5's re -Admitted 8/5/20; -Discharged 8/7/20; -Diagnosed with Pos Disruptive Mood Dys Unspecified Trauma; -10 years old;	t Traumatic Stress Disorder, regulation Disorder, and					
	Reports dated 7/1/20 -Level I Incident Rep physical altercation b and Former Client #/	ort dated 7/22/20 involved a between Former Client #3 A1 witnessed by Staff #5 ere was no documentation of					
	revealed: -Attended a summer recreational facility ir Former Client #A1; -There was one staff times. There was su	D with Former Client #1 day camp at a local a neighboring town with present at the facility most pposed to be two staff staff quit because of the					
	members at the local Client #1 and Forme summer day camp re	9/4/20 with management I recreational facility Former r Client #A1 attended evealed: d not stay with the campers					

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From pag	e 87	V 296			
	Interview on 8/12/20 with Former Client #2 revealed: -There was one to two staff working on 1st or 2nd shift.					
	when the director of discovered that Form physical altercation w led to Former Client # 3 in the throat; -"I could not go back stabbed me in the th fought her back;" -One or two staff wor staff worked at lunch one staff worked at night	cheerleading camp; stay in camp all summer				
	Department of Socia Worker revealed: -Had multiple concer -Former Client #3 att which the DSS Socia the middle of July, 20 informed she could r verbal altercation wit	ended a cheerleading camp al Worker found out about in 020. Former Client #3 was not return to camp due to a h staff at the camp; umentation regarding what				
	Adoption Recruiter re	with Former Client #3's evealed: ended three different camps				

Division of Health Service Regu

6899

If continuation sheet 88 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MUI 026 226	B. WING			
	ROVIDER OR SUPPLIER	MHL036-336	DDRESS, CITY, STATE,		09	/29/2020
FRESH NE	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETI DATE	
V 296	Continued From page	e 88	V 296			
	because she was mo to her behaviors.	oved from camp to camp due				
	revealed: -Former Client #3 was camp because of her -Former Client #4 was camp for kissing boys -Former Client #1 att -Was in a peer's bed sexualized behaviors -Staff usually worked -90% of the time ther facility; -Staff would get fired work. Interview on 8/12/20 Social Worker reveal	is kicked out of summer day s; ended summer day camp; room and engaged in s with Former Client #2; alone; re was just one staff at the or quit or would not come to with Former Client #4's DSS				
	revealed: -There were two staff staff during the overn she would wake up of Interview/Observation approximately 2:15pr -Two staff worked pe -Staff #5 had her pho the interview and whi the background. Staff answering questions	n on 9/11/20 at m with Staff #5 revealed: r shift; one on speaker phone during ispering could be heard in ff #5 hesitated prior to . Staff #5 was asked if she				
		se during the interview. 9 with anyone else during the				

STATEMEN	of Health Service Regu r of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-336	B. WING		09	09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
FRESH NI	EW START		NTINGTON DRIVE				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 296	Continued From page	e 89	V 296				
	Interview on 9/21/20 revealed: -Two staff worked per	with Associate Professional					
		with Staff #8 revealed:					
	Staff #12 revealed: -Only one staff preser -Was often left with cl and Sister Facility A; -Worked alone on 7/6 facility and Sister Fac Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -Always scheduled tw This deficiency is cross	with Licensee Professional #1 and e Director revealed:					
V 297	P 10A NCAC 27G .170 LICENSED PROFES (a) Face to face clinic provided in each facil week by a licensed pro- this Rule, licensed pro- individual who holds a license issued by the a human service prof	SIONALS cal consultation shall be ity at least four hours a rofessional. For purposes of ofessional means an a license or provisional governing board regulating ession in the State of North nce-related disorders this ed Clinical Addiction	V 297				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 90 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		MHL036-336			09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, NTINGTON DRIVE	, ZIP CODE		
FRESH NE	EW START		NA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 297	Continued From page	e 90	V 297			
	 (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. 					
		record review, and				
	Former Client #1's re -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disr Disorder and Attentio Disorder; -11 years old; -History of assault, pr poor hygiene, discus at day camp and pos	8/12/20 and 8/18/20 of ecord revealed: ruptive Mood Dysregulation on Deficit Hyperactivity roperty destruction, rage, sing sexualized activity while esible sexualized behaviors in pehavioral outbursts weekly.				
	Former Client #2's re -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Pos	8/12/20 and 8/18/20 of cord revealed: t Traumatic Stress Disorder Hyperactivity Disorder;				

(EACH DEFICIENC' REGULATORY OR L ontinued From page years old; istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	4460 HL GASTOL ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 9 91 estruction and self-harm. (12/20 and 8/18/20 of	A. BUILDING: B. WING ADDRESS, CITY, STATE JINTINGTON DRIVE NIA, NC 28056 ID PREFIX TAG V 297		09/29/2020 (X5) COMPLET DATE
START SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L ontinued From page years old; istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	STREET / 4460 HL GASTOI ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 9 91 estruction and self-harm. /12/20 and 8/18/20 of	ADDRESS, CITY, STATE UNTINGTON DRIVE NIA, NC 28056 ID PREFIX TAG	, ZIP CODE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLET
START SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L ontinued From page years old; istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	4460 HL GASTOL ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 9 91 estruction and self-harm. (12/20 and 8/18/20 of	INTINGTON DRIVE NIA, NC 28056	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L ontinued From page years old; istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	GASTO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 9 91 estruction and self-harm. /12/20 and 8/18/20 of	NIA, NC 28056	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
(EACH DEFICIENC' REGULATORY OR L ontinued From page years old; istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 9 91 estruction and self-harm. /12/20 and 8/18/20 of	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
years old; istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	estruction and self-harm. /12/20 and 8/18/20 of	V 297		
istory of property de eview on 8/11/20, 8/ rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;	/12/20 and 8/18/20 of			
rmer Client #3's red dmitted 6/12/20; ischarged 8/4/20;				
sorder, Post Traum opositional Defiant I 3 years old; istory of running aw known males, incre gression. eview on 8/11/20, 8/ rmer Client #4's red dmitted 4/24/20; ischarged 8/6/20;	Disorder, Depression; vay, getting in the car with eased sexual behaviors, and /12/20 and 8/18/20 of cord revealed:			
3 years old; istory of property do xualized behaviors;	estruction, physical assault, , sexual abuse/rape, and			
rmer Client #5's red dmitted 8/5/20; ischarged 8/7/20;	cord revealed:			
sruptive Mood Dysr specified Trauma;) years old;	egulation Disorder, and			
mmands. erview on 8/14/20 v vealed:	with Former Client #1			
province and the second s	positional Defiant I years old; story of running aw mown males, incre- gression. view on 8/11/20, 8, mer Client #4's re- limitted 4/24/20; scharged 8/6/20; agnosed with Opp- d Unspecified Trau years old; story of property de ualized behaviors are allegations of ak view on 8/11/20, 8, mer Client #5's re- limitted 8/5/20; scharged 8/7/20; agnosed with Post ruptive Mood Dysr specified Trauma; years old; story of anger, agg nmands.	story of running away, getting in the car with mown males, increased sexual behaviors, and gression. view on 8/11/20, 8/12/20 and 8/18/20 of mer Client #4's record revealed: Imitted 4/24/20; scharged 8/6/20; agnosed with Oppositional Defiant Disorder 4 Unspecified Trauma; years old; story of property destruction, physical assault, tualized behaviors, sexual abuse/rape, and se allegations of abuse. view on 8/11/20, 8/12/20 and 8/18/20 of mer Client #5's record revealed: Imitted 8/5/20; scharged 8/7/20; agnosed with Post Traumatic Stress Disorder, ruptive Mood Dysregulation Disorder, and specified Trauma; years old; story of anger, aggression, and auditory nmands.	positional Defiant Disorder, Depression; years old; story of running away, getting in the car with known males, increased sexual behaviors, and gression. view on 8/11/20, 8/12/20 and 8/18/20 of mer Client #4's record revealed: imitted 4/24/20; scharged 8/6/20; agnosed with Oppositional Defiant Disorder d Unspecified Trauma; years old; story of property destruction, physical assault, tualized behaviors, sexual abuse/rape, and are allegations of abuse. view on 8/11/20, 8/12/20 and 8/18/20 of mer Client #5's record revealed: imitted 8/5/20; scharged 8/7/20; agnosed with Post Traumatic Stress Disorder, ruptive Mood Dysregulation Disorder, and specified Trauma; years old; story of anger, aggression, and auditory nmands. erview on 8/14/20 with Former Client #1 ealed: e Licensed Professional/Qualified	positional Defiant Disorder, Depression; years old; story of running away, getting in the car with nown males, increased sexual behaviors, and gression. view on 8/11/20, 8/12/20 and 8/18/20 of mer Client #4's record revealed: imitted 4/24/20; scharged 8/6/20; agnosed with Oppositional Defiant Disorder 8 Unspecified Trauma; years old; story of property destruction, physical assault, rualized behaviors, sexual abuse/rape, and se allegations of abuse. view on 8/11/20, 8/12/20 and 8/18/20 of mer Client #5's record revealed: lmitted 8/5/20; scharged 8/7/20; agnosed with Post Traumatic Stress Disorder, ruptive Mood Dysregulation Disorder, and specified Trauma; years old; story of anger, aggression, and auditory nmands. erview on 8/14/20 with Former Client #1 ealed: e Licensed Professional/Qualified

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 297	Continued From pag	e 92	V 297			
		e to the facility "every other and individual sessions.				
	Interview on 8/12/20 revealed:	with Former Client #2				
	-The Licensed Professional/Qualified Professional #2 would complete sessions on					
		imes on other days of the				
	week but Former Clie how often the sessio	ent #2 could not remember ns took place.				
	Interview on 9/3/20 v revealed:					
	-Would meet with the	e Licensed d Professional #2 but could				
	not identify how ofter -"She (Licensed Prof	n the sessions would occur; fessional/Qualified				
	Professional #2) was	-				
	Interview on 8/13/20 revealed:	with Former Client #4				
	-Met with Licensed P					
	Professional #2 for s -There was a total of ended.	essions; 5 sessions and then therapy				
	Interview/Observatio	n on 9/10/20 at				
	Professional/Qualifie	m - 3:10pm with Licensed d Professional #2 revealed: ility and Sister Facility A				
	since 2017; -Provided individual a	and group therapy twice				
	weekly; -Used virtual session	ns during the start of the				
		ned face to face sessions in				
	-Last time at Sister F	acility A was 9/2/20 when				
	she saw Former Clie at the facility;	nt #2 who was the only client				
	-Upon confirming wit	h the Licensed				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING	·····	09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
RESH N	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 297	Continued From pag	e 93	V 297			
	last date of service w #2, the call was sudo 2:50pm; -Return calls to the L Professional/Qualifie made immediately up went to voicemail and requesting a return of -Call was returned by Professional/Qualifie who reported her cel -During the return ca Professional/Qualifie she made a mistake calendar correctly du date of service at the Former Client #2 was Facility A; -Will send copies of I Professional/Qualifie a secured and encry	d Professional #2's phone oon disconnection of the call d a message was left all; / the Licensed d Professional #2 at 2:57pm I phone battery went dead; II, the Licensed d Professional #2 revealed and did not view her uring the initial call. The last e facility was 8/2/20 when is the only client at Sister				
	Based upon record re #2, #3, #4, and #5 ard dates, there were no 9/2/20 although the L Professional/Qualifie identified this as the aforementioned reco Former Clients #1, # present in the facility Licensed Professional identified only Former Review on 9/11/20 or	eviews of Former Clients #1, nd their respective discharge clients in the facility on Licensed d Professional #2 initially last date of service. The rd reviews also indicated that 2, #3, and #4 were all on 8/2/20 although the al/Qualified Professional #2 er Client #2's presence.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE	03	12512020
RESH NE	W START		INTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 297	conversation on this work and do not fore requested document I will have this inform tomorrow night when not have access to the Review on 9/14/20 of DHSR surveyor from Professional/Qualifie 9/11/20 at 8:09pm re -Licensed Profession #2's notes on Forme sent via an attachme email; -No documentation of Professional/Qualifie	d 9/10/20 at 6:54pm vanted to follow up per our afternoon. I still currently at see being able to get you the ation this evening. However, hation to you no later than a I come in from work as I do nese files." f email correspondence to the Licensed d Professional #2 dated vealed: nal/Qualified Professional r Clients #1 and #4 were ent to a secure and encrypted of Licensed d Professional #2 services Clients #A1, #A2, #A3, and	V 297			
	#1/Director/Qualified Licensee #2/Execution -The Licensed Profese Professional #2 was Sessions with the Lice Professional #2 were the start of the panded in-person sessions.	Professional #1 and ve Director revealed: ssional/Qualified at the facility weekly. censed Professional/Qualified e conducted virtually during emic and then returned to				
V 364	NCAC 27G .1701 Sc rule violation.	oss referenced into 10A cope (V293) for a Type A1 tional Rights in 24 Hour	V 364			

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	MHL036-336	DDRESS, CITY, STATE		09	9/29/2020
			NTINGTON DRIVE	, ZIF CODE		
FRESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 364	Continued From page 95		V 364			
	122C-51 through G.S. who is receiving treat 24-hour facility keeps (1) Send and receiving access to writing mat assistance when nec (2) Contact and con and at no cost to the physicians, and priva developmental disabil professionals of his c (3) Contact and con there is a client advoor The rights specified in restricted by the facilit exercise these rights (b) Except as provid of this section, each a treatment or habilitatif times keeps the right (1) Make and receivin (2) Receive visitors a.m. and 9:00 p.m. for hours daily, two hours p.m.; however visiting over therapies; (3) Communicate ar supervision with indiving upon the consent of t (4) Make visits outsit unless:	e rights enumerated in G.S. 5. 122C-61, each adult client timent or habilitation in a 5 the right to: e sealed mail and have terial, postage, and staff essary; sult with, at his own expense facility, legal counsel, private te mental health, ilities, or substance abuse hoice; and sult with a client advocate if cate. In this subsection may not be ity and each adult client may at all reasonable times. led in subsections (e) and (h) adult client who is receiving on in a 24-hour facility at all to: te confidential telephone e calls shall be paid for by of making the call or made g party; between the hours of 8:00 or a period of at least six s of which shall be after 6:00 g shall not take precedence and meet under appropriate viduals of his own choice				

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING: B. WING			
		MHL036-336			09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE,	ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET DATE
V 364	Continued From pag	e 96	V 364			
	the result of the client's being charged with a					
		ng a crime involving an				
	assault with a deadly	weapon, and the				
	respondent was foun	nd not guilty by reason of				
	insanity or incapable	of proceeding;				
		oluntarily admitted or				
	committed to the facility while under order of commitment to a correctional facility of the					
		,				
		rection of the Department of				
	Public Safety; or					
		ng held to determine capacity				
	to proceed pursuant					
	A court order may expressly authorize visits otherwise prohibited by the existence of the					
	conditions prescribed by this subdivision;					
	(5) Be out of doors daily and have access to					
	()	ent for physical exercise				
	several times a week					
		pited by law, keep and use				
		d possessions, unless the				
		determine capacity to				
	proceed pursuant to	G.S. 15A-1002;				
	(7) Participate in rel					
		l a reasonable sum of his				
	own money;					
		license, unless otherwise				
		r 20 of the General Statutes;				
	and	individual atomas anala far				
		individual storage space for				
	his private use.	e rights enumerated in G.S.				
	122C-51 through G.S					
	-	S. 122C-61, each minor client				
		tment or habilitation in a				
		he right to have access to				
	proper adult supervis	-				
		nor's status as a developing				
	individual, the minor					
	opportunities to enab					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
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NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
RESH NI	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
V 364	Continued From page	e 97	V 364			
	and intellectual imma 24-hour facility shall j structure, supervision the rights given to the The facility shall also reasonable efforts to client receives treatma adult clients unless the minor client dictate of Each minor client dictate of Each minor client dictate of Each minor client wh habilitation from a 24 (1) Communicate an guardian or the agen custody of him; (2) Contact and com or that of his legally r cost to the facility, leg physicians, private m disabilities, or substa his or his legally resp (3) Contact and com there is a client advor The rights specified in restricted by the facili may exercise these r (d) Except as provid of this section, each n treatment or habilitati the right to: (1) Make and receiv distance calls shall be time of making the ca receiving party; (2) Send and receiv writing materials, pos when necessary;	of the physical, emotional, turity of the minor, the provide appropriate and control consistent with eminor pursuant to this Part. , where practical, make ensure that each minor nent apart and separate from the treatment needs of the therwise. o is receiving treatment or -hour facility has the right to: nd consult with his parents or cy or individual having legal sult with, at his own expense esponsible person and at no gal counsel, private ental health, developmental nce abuse professionals, of onsible person's choice; and sult with a client advocate, if				

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
()(1)10		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	O THE APPROPRIATE	COMPLETI DATE
V 364	Continued From pag	e 98	V 364			
	visitors between the hours of 8:00 a.m. and 9:00					
		t least six hours daily, two				
		be after 6:00 p.m.; however				
		precedence over school or				
	therapies;					
	(4) Receive special	education and vocational				
		e with federal and State law;				
	(5) Be out of doors	daily and participate in play,				
	recreation, and phys	ical exercise on a regular				
	basis in accordance	with his needs;				
	(6) Except as prohile	pited by law, keep and use				
	personal clothing and	d possessions under				
	appropriate supervis	ion, unless the client is being				
	neld to determine capacity to proceed pursuant to G.S. 15A-1002;					
	(7) Participate in rel					
		individual storage space for				
	the safekeeping of p					
	()	and spend a reasonable sum				
	of his own money; ar					
	()	license, unless otherwise				
		r 20 of the General Statutes.				
	()	rated in subsections (b) or (d)				
	,	e limited or restricted except				
		essional responsible for the				
		ent's treatment or habilitation				
	•	nent shall be placed in the				
	for the restriction. The	dicates the detailed reason				
		e restriction shall be ed to the client's treatment or				
		restriction is effective for a				
		30 days. An evaluation of				
		be conducted by the				
		l at least every seven days,				
		triction may be removed.				
	Each evaluation of a	-				
		lient's record. Restrictions on				
	rights may be renew					
		/ the qualified professional in				
		,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, INTINGTON DRIVE	, ZIP CODE		
RESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From page	e 99	V 364			
	Continued From page 99 the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.					
	failed to ensure comr with parents or guarc individual having lega by the facility affectin	as evidenced by: and record review, the facility munication and consultation dian or the agency or al custody without restriction ag 5 of 5 audited former ts #1, #2, #3, #4, and #5).				
	#1's record revealed: -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disr	nd 8/12/20 of Former Client : ruptive Mood Dysregulation on Deficit Hyperactivity				
	Review on 8/11/20 ai #2's record revealed:	nd 8/12/20 of Former Client				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
			NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From page	e 100	V 364			
	-Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder; -9 years old.					
	#3's record revealed: -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atte Disorder, Post Traum	ntion Deficit Hyperactivity				
	#4's record revealed: -Admitted 4/24/20; -Discharged 8/6/20;	ositional Defiant Disorder				
	#5's record revealed: -Admitted 8/5/20; -Discharged 8/7/20; -Diagnosed with Pos	t Traumatic Stress Disorder, regulation Disorder, and				
	revealed: -Could make calls to had to be present in discussing peers; -Was able to call her	with Former Client #1 her grandparents but staff the room so there was no Social Worker but Licensee Professional #1 or Licensee				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 364	Continued From pag	e 101	V 364			
	during the calls.					
	Department of Socia Worker revealed: -Would have facetime -Former Client #1 wo staff involvement but	with Former Client #1's I Services (DSS) Social e calls with Former Client #1; buld speak independent of staff would always keep m" and it was obvious the oximity.				
	Interview on 9/3/20 w revealed: -Did not have privacy -Staff listened to all to -"They (staff) were	/ during telephone calls; elephone calls;				
	Social Worker reveal -Staff almost always	with Former Client #3's DSS ed: supervised the calls when d the Social Worker spoke to				
	Adoption Recruiter re	with Former Client #3's evealed: cy on telephone calls.				
	Mother revealed: -Former Client #3 wo calls were always on Client #1 could be he background; -Two to three times the staff when staff would	he calls were terminated by d say to Former Client #3				
	revealed:	g to allow that!" with Former Client #4 er were monitored (due to a				

TATEMENT OF DEFICIENCIES (X1 ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING)/29/2020
NAME OF Pr	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, INTINGTON DRIVE	ZIP CODE		
RESH NE	W START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From pag	e 102	V 364			
- s - v f t v -	court order); -Calls with her DSS worker were monitored as staff would stay in the area and listen. Interview on 8/12/20 with Former Client #4's DSS Social Worker revealed: -Would make calls to Former Client #4 when she was at the summer day camp as there was no					
	privacy on calls when she was at the facility; -"Brighter Dayz (Licensee) staff would not allow fully private conversations. The staff would listen					
	to conversations and would hang up the phone when [Former Client #4] said she was upset" -Was informed by Licensee #2/Executive Director policy was for all calls to be monitored;					
	-The facility never pu monitoring phone ca	t anything in writing about				
	hatefully during calls -Had a video chat wi took place at the hor	with Former Client #4; th Former Client #4 which ne of Licensee #2/Executive thought that was highly				
	unusual.	thought that was highly				
	-Clients were allowed to 15 minutes with st	with Staff #5 revealed: d to make phone calls for 10 aff monitoring all calls via				
		owed to call individuals on t approved by their legal				
	revealed:	with Associate Professional				
	legal guardian appro -Phone calls were m	d to make phone calls if their ved of the individuals called; onitored on a client by client calls on speaker phone for				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
			A. BUILDING:	A. BUILDING:			
		MHL036-336	B. WING		09/29/2020		
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 364	Continued From page	e 103	V 364				
	-Clients were allowed individuals on their lis the legal guardian; -Calls were monitore -Had clients place the and staff sat next to t calls. Interview on 9/22/20 revealed: -The clients were allo	e phone on speaker phone he clients and listened to the with Former Staff #12 owed to use the telephone o be monitored with the					
	calls on speaker pho -Former Client #4's p mother needed to be -Was not "running a l privacy on phone cal -Clients were allowed wanted to but calls w approved call list.	Professional #1 and ve Director revealed: ad their phone calls directed to put all personal ne; hone calls with her biological monitored per court order; pootcamp" with not allowing ls; d to use the phone when they					
	NCAC 27G .1701 Sc rule violation.	ope (V293) for a Type A1					
V 366	27G .0603 Incident F 10A NCAC 27G .060 RESPONSE REQUI CATEGORY A AND E	REMENTS FOR	V 366				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED	
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	ROVIDER OR SUPPLIER	MHL036-336	DDRESS, CITY, STATE, Z		08	0/29/2020	
FRESH NE	EW START		NIA, NC 28056				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
V 366	Continued From page	e 104	V 366				
	implement written por response to level I, II shall require the prov (1) attending to of individuals involved (2) determining (3) developing measures according timeframes not to exe (4) developing to prevent similar incl specified timeframes (5) assigning p for implementation of preventive measures (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a)(1 (b) In addition to the Paragraph (a) of this shall address inciden regulations in 42 CFF (c) In addition to the Paragraph (a) of this providers, excluding develop and implement their response to a le while the provider is of or while the client is of The policies shall req by: (1) immediately	or III incidents. The policies ider to respond by: the health and safety needs d in the incident; and implementing corrective to provider specified ceed 45 days; and implementing measures idents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and ; confidentiality requirements article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and documentation regarding) through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers ts as required by the federal R Part 483 Subpart I. requirements set forth in Rule, Category A and B ICF/MR providers, shall ent written policies governing vel III incident that occurs delivering a billable service on the provider's premises. juire the provider to respond y securing the client record e client record;					

Division of Health Service Regulation STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRESH N	EW START		NTINGTON DRIVE NIA, NC 28056			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From page	e 105	V 366			
	 (D) transferring review team; (2) convening a review team within 24 internal review team within 24 internal review team within 24 internal review team shall correview thin five working dapreliminary findings of LME in whose catcher located and to the LM if different; and (D) issue a final owner within three more final report shall be see catchment area the performation of the correview of the correr and shall mark minimizing the occurrent and shall mark minimizing the occurent and shall mark minimizing the occurent and shall mar	the copy's completeness; and the copy to an internal a meeting of an internal 4 hours of the incident. The shall consist of individuals d in the incident and who for the client's direct care or al oversight of the client's of the incident. The internal mplete all of the activities as copy of the client record to nd causes of the incident dations for minimizing the incidents; er information needed; en preliminary findings of fact ays of the incident. The of fact shall be sent to the nent area the provider is ME where the client resides, I written report signed by the onths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The all address the issues nal review team, shall uments pertinent to the ake recommendations for rence of future incidents. If d for the report are not months of the incident, the ovider an extension of up to nit the final report; and y notifying the following: sponsible for the catchment				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From pag	e 106	V 366			
	Rule .0604;(B)the LME wdifferent;(C)the providefor maintaining and utreatment plan, if diffprovider;(D)the Departr(E)the client'sapplicable; and	erent from the reporting				
	failed to ensure all in	as evidenced by: and record review, the facility icidents were reported as y and procedure. The				
	Former Client #1's re -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disr	8/12/20 and 8/18/20 of ecord revealed: ruptive Mood Dysregulation on Deficit Hyperactivity				
	-11 years old; -Discharge Summary #1/Director/Qualified 8/6/20 revealed diffic boundaries and pers poor hygiene, and in destruction, and vert	y completed by the Licensee Professional #1 dated sulty with respecting onal space, struggles with cidents of profanity, property bal and physical aggression; ate for July, 2020 revealed				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:	A. BUILDING:			
		MHL036-336	B. WING		09/29/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
FRESH NE	W START		NTINGTON DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
V 366	Continued From page	e 107	V 366				
	Former Client #1 mar a summer day camp intercourse in the pas property destruction physical aggression of concerns were report behaviors of being un resulting in property of defiance at least 4 to Review on 8/11/20, 8 Former Client #2's re -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Pos and Attention Deficit -9 years old. Review on 8/11/20, 8 Former Client #3's re -Admitted 6/12/20; -Discharged 8/4/20;	de up stories while attending about having sexual st. Anger outbursts including had increased as well as towards staff. Unspecified ted by camp staff. Client had nable to control her impulses destruction, disrespect, and 5 times per week. 8/12/20 and 8/18/20 of ecord revealed: t Traumatic Stress Disorder Hyperactivity Disorder; 8/12/20 and 8/18/20 of					
	Disorder, Post Traum Oppositional Defiant -13 years old; -Comprehensive Clin addendum complete Professional/Qualifie	natic Stress Disorder, Disorder, Depression; nical Assessment (CCA)					
	Client is not able to boundaries and will to others. Client feels t	rubbing on them and					
vision of Har	-	ing foul languageClient					

STATE FORM

	of Health Service Regu						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336	B. WING		09	/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
FRESH NE	EW START		NTINGTON DRIVE				
		GASTON	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 366	Continued From pag	e 108	V 366				
	appropriate boundari staff and peers"	ies and the personal space of					
	Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #4's record revealed: -Admitted 4/24/20; -Discharged 8/6/20; -Diagnosed with Oppositional Defiant Disorder and Unspecified Trauma; -13 years old;						
- F 8	-CCA Addendum completed by the Licensed Professional/Qualified Professional #2 dated 8/1/20 revealed: client has difficulty with sexual intimacy, sexual abuse/rape, and displays						
	sexually inappropriat Client #4] makes sex displays sexual gestu physically and verba and peers at group h bullies younger peers	the behaviors and "[Former tual comments to peers and ures[Former Client #4] is lly aggressive towards staff home[Former Client #4] is in the group homeShe iff and peers in her attempt to					
	#1/Director/Qualified 8/6/20 revealed stea struggling with telling	y completed by Licensee Professional #1 dated ling peers' clothing, g the truth, physical assault by e couch, and a sexual					
	-Treatment Plan upd Client #4 manifested factual and continues pushed a client off a client's personal pictor	ate 8/6/20 revealed Former several stories that are not s to be untruthful, physically couch, and took another ures and ripped the pictures					
		n the garbage. nsee #1/Director/Qualified Licensee #2/Executive					
	8/10/20 at approxima	nt reports were made on ately 10:40am via phone call :22am and 8/11/20 at					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	E SURVEY PLETED	
		MHL036-336 B. WIN				120/2020	
NAME OF P	ROVIDER OR SUPPLIER		B. WING 09/29/2020 ET ADDRESS, CITY, STATE, ZIP CODE 09/29/2020				
				,			
FRESH NI	EW START	GASTO	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
V 366	Continued From pag	e 109	V 366				
	10:17am via email co	prrespondence.					
	from 7/1/20 - 8/7/20 r -Only one incident re Client #3;	port submitted on Former were submitted for Former					
	Professional #2 and Director for the Incide made on 9/10/20 at 1 correspondence. Lice	nsee #1/Director/Qualified Licensee #2/Executive ent Reporting Policy was 12:31pm via email censee #1/Director/Qualified an email in response to the					
	sent by Licensee #1/ Professional #2 rever - "In regard to your information (including we can provide when week. It is my under #2/Executive Directo several times during determine what your everything without det	aled: r request for the other g Incident Reporting Policy), n we return to Charlotte next standing that [Licensee r] has reached out to you this investigation in order to needed so you would have elay. Unfortunately there will g that both of us are out of					
	by the Licensee #2/E at 8:12pm revealed: -"I reached out to you inform you that we w afternoon in order go requested (including could not reach you	f email correspondence sent executive Director on 9/14/20 I several times today to ill return to work later this of get you the information you Incident Reporting Policy). I so I contacted [Division of lation (DHSR) Western					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
				A. BUILDING:			
		MHL036-336	B. WING		09	9/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, INTINGTON DRIVE	, ZIP CODE			
FRESH NI	EW START		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 366	Continued From pag	e 110	V 366				
	Branch Manager], in documents reques attached"	order to get clarification on tedplease see the					
	telephone upon retur being off from 9/15/2 calls from the Licens were received on 9/1 at 2:02pm with no vo	f the DHSR's surveyor's on of the DHSR surveyor from 0 - 9/17/20 revealed two ee #2/Executive Director 14/20. One call was received bicemail message being left eived on 3:33pm with a call.					
	Incident Reporting P -"Any incidentrega reported, using the a Form, within twenty-1 an incidentis def	arding clients shall be pproved incident Report four hours of the incident fined as any event which is ne routine operation of the					
	Staff #12 revealed: -Worked at the facilit -Clients from the faci intermingled and spe -On 7/6/20 during he she was working alou Former Client #A3 w up Former Clients #A from camp. After pic camp, a fight ensued five clients while Form Former Staff #12 cal was readily available best she could to ma evening at 11:18pm,	and 9/22/20 with Former y and Sister Facility A; lity and Sister Facility A often ent time together; er last shift at Sister Facility A ne. She was asked to take ith Former Client #2 to pick A1 and #A4 and Client #1 cking up the clients from d in the van which involved all mer Staff #12 was driving. led for assistance, but none e. Former Staff #12 did the intain order. Later that Former Staff #12 received a nsee #1/Director/Qualified					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		B WING					
		MHL036-336			09	/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE JNTINGTON DRIVE	, ZIP CODE			
FRESH NE	EW START		NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 366	Continued From page	e 111	V 366				
		l they were on a recorded gating Former Staff #12.					
	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment regard reports.	Professional #1 and					
		ss referenced into 10A ope (V293) for a Type A1					
V 367	27G .0604 Incident R	Reporting Requirements	V 367				
	 v 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; 						
	 (3) type of incid (4) description (5) status of the 						

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MUI 026 226	B. WING			N20/2020
	ROVIDER OR SUPPLIER	MHL036-336	ADDRESS, CITY, STATE		09	/29/2020
			INTINGTON DRIVE	,		
RESH NE	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From pag	le 112	V 367			
	cause of the incident	t [.] and				
	(6) other individuals or authorities notified					
	or responding.					
		B providers shall explain any				
		te information. The provider				
	shall submit an upda	ted report to all required				
	report recipients by t	he end of the next business				
	day whenever:					
		er has reason to believe that				
	-	in the report may be				
		ng or otherwise unreliable; or				
		er obtains information				
	required on the incident form that was previously unavailable.					
		B providers shall submit,				
		LME, other information				
		he incident, including:				
		cords including confidential				
	information;	-				
	(2) reports by	other authorities; and				
		er's response to the incident.				
		B providers shall send a copy				
		t reports to the Division of				
	,	lopmental Disabilities and				
		ervices within 72 hours of he incident. Category A				
	providers shall send					
		client death to the Division of				
		Ilation within 72 hours of				
	-	he incident. In cases of				
	-	even days of use of seclusion				
	-	ider shall report the death				
		ired by 10A NCAC 26C				
	.0300 and 10A NCA					
		B providers shall send a				
		e LME responsible for the				
		re services are provided.				
	-	ubmitted on a form provided electronic means and shall				
	by the Secretary Via	CICCUUTIIC THEATIS ATTU STAIL				

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		MHL036-336			09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident;		V 367			
	 the definition of a lev (3) searches o (4) seizures of the possession of a c (5) the total nuincidents that occurred (6) a statement been no reportable in incidents have occurred meet any of the crited 	mber of level II and level III ed; and t indicating that there have notidents whenever no red during the quarter that ria as set forth in Paragraphs le and Subparagraphs (1)				
	failed to report all Lev (local management e	and record review, the facility vel III incidents to the LME entity) responsible for the re services are provided coming aware of the				
	Former Client #1's re -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disr	8/12/20 and 8/18/20 of cord revealed: ruptive Mood Dysregulation on Deficit Hyperactivity				

STATE FORM

STATEMENT	of Health Service Regu of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	MHL036-336 B. WING		09/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
	EW START	4460 HU	INTINGTON DRIVE			
	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From page	e 114	V 367			
	Former Client #2's re -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Post	v/12/20 and 8/18/20 of acord revealed: t Traumatic Stress Disorder Hyperactivity Disorder;				
	Former Client #3's re -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atten Disorder, Post Traum	ntion Deficit Hyperactivity				
	Former Client #4's re -Admitted 4/24/20; -Discharged 8/6/20;	ositional Defiant Disorder				
	-On 7/31/20, 8/1/20, a Department of Social multiple allegations o Clients #1, #2, #3, an included, but were no stripping Former Clie body in the shower, s	Professional #1 revealed: and 8/3/20, the local Services was investigating of abuse involving Former and #4. The allegations but limited to, staff forcibly nt #1 and scrubbing her sexual assault of Former Client #4, and Former Client				
		f the North Carolina Incident ent System (NC IRIS) for				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 367	Continued From page	e 115	V 367			
	incident on 8/3/20 for made by Former Clied did not mention the m than Former Client # threatened by a local Services Social Work facility; -Incident report subm incident on 8/3/20 for she was the victim of Former Client #4. Th completed on Forme was involved in the ir -Incident report subm an incident on 7/21/2 she ran away and wa Local law enforceme -Searched website by	hitted on 8/9/20 regarding an a "consumer allegation" nt #1. The incident report ature of the allegation other 1 reported she felt Department of Social ter who was investigating the hitted on 8/4/20 regarding an Former Client #2 alleging inappropriate touching by here was no incident report r Client #4 even though she ncident. hitted on 7/22/20 regarding 0 for Former Client #1 when as missing for 45 minutes. Int was involved. y county, facility name, each client name. No other located. with Licensee				
	Licensee #2/Executiv -No comment regard reports. This deficiency is cro NCAC 27G .1701 Sc					
V 513	rule violation. 27E .0101 Client Rig Alternative	hts - Least Restictive	V 513			
	10A NCAC 27E .010 ALTERNATIVE (a) Each facility shal	1 LEAST RESTRICTIVE				

		A. BUILDING:			
				-	
VIDER OR SUPPLIER	MHL036-336	ADDRESS, CITY, STATE		09/	29/2020
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START	GASTO	NIA, NC 28056			
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
Continued From page 116		V 513			
hese include:1)using the leppropriate settings a2)promoting ckills that are alternateelf or others;3)providing chheaningful to the clieat4)sharing of cne client/legally respb)The use of a restrocedure designed tlways be accompanheaver dignity and restthe use of a restnocedure designed tlways be accompanheaver dignity and restthe using the in1)using the innd	ast restrictive and most and methods; coping and engagement tives to injurious behavior to noices of activities ints served/supported; and control over decisions with onsible person and staff. rictive intervention o reduce a behavior shall ied by actions designed to spect during and after the nclude: tervention as a last resort;				
assed on interview at ailed to ensure a res ffecting 5 of 5 audite clients #1, #2, #3, #4 eview on 8/11/20 ar 1's record revealed: Admitted 12/27/19; Discharged 8/6/20; Diagnosed with Disru bisorder and Attentio bisorder;	nd record review, the facility pectful environment ed former clients (Former , and #5). The findings are: nd 8/12/20 of Former Client uptive Mood Dysregulation				
	ontinued From page at promote a safe a hese include:) using the le opropriate settings a cills that are alternate eff or others;) providing cf eaningful to the clies) sharing of c e client/legally resp) The use of a rest rocedure designed t ways be accompan sure dignity and rest tervention. These i) using the in nd) employing t ained in its use. his Rule is not met ased on interview a iled to ensure a res fecting 5 of 5 audite lients #1, #2, #3, #4 eview on 8/11/20 ar 1's record revealed: admitted 12/27/19; Discharged 8/6/20; Diagnosed with Dism isorder; 1 years old.	ontinued From page 116 at promote a safe and respectful environment. hese include:) using the least restrictive and most opropriate settings and methods;) promoting coping and engagement dills that are alternatives to injurious behavior to elf or others;) providing choices of activities eaningful to the clients served/supported; and) sharing of control over decisions with e client/legally responsible person and staff.) The use of a restrictive intervention rocedure designed to reduce a behavior shall ways be accompanied by actions designed to sure dignity and respect during and after the tervention. These include:) using the intervention as a last resort; d) employing the intervention by people ained in its use. his Rule is not met as evidenced by: ased on interview and record review, the facility iled to ensure a respectful environment fecting 5 of 5 audited former clients (Former lients #1, #2, #3, #4, and #5). The findings are: eview on 8/11/20 and 8/12/20 of Former Client 1's record revealed: dmitted 12/27/19; Discharged 8/6/20; Diagnosed with Disruptive Mood Dysregulation isorder and Attention Deficit Hyperactivity isorder; 1 years old.	ontinued From page 116 V 513 at promote a safe and respectful environment. nese include:) using the least restrictive and most popropriate settings and methods;) promoting coping and engagement cills that are alternatives to injurious behavior to aff or others; providing choices of activities eaningful to the clients served/supported; and sharing of control over decisions with e client/legally responsible person and staff. the twention 0) The use of a restrictive intervention occedure designed to reduce a behavior shall ways be accompanied by actions designed to sure dignity and respect during and after the tervention. These include:) using the intervention as a last resort; nd employing the intervention by people ained in its use. nis Rule is not met as evidenced by: ased on interview and record review, the facility iled to ensure a respectful environment facting 5 of 5 audited former clients (Former lients #1, #2, #3, #4, and #5). The findings are: eview on 8/11/20 and 8/12/20 of Former Client 1's record revealed: Visingnosed with Disruptive Mood Dysregulation isorder; Diagnosed with Disruptive Mood Dysregulation isorder; isorder; 1 years old. eview on 8/11/20 and 8/12/20 of Former Client	DEFICIENCY) ontinued From page 116 V 513 at promote a safe and respectful environment. ness include:) using the least restrictive and most porporiate settings and methods;) promoting coping and engagement (ills that are alternatives to injurious behavior to alf or others;)) providing choices of activities eaningful to the clients served/supported; and))) that are alternatives to injurious behavior to all ways be accompanied by actions designed to sure dignity and respect during and after the tervention. These include:)) using the intervention as a last resort; and) of) employing the intervention by people ained in its use.	Image DEFICIENCY) ontinued From page 116 V 513 at promote a safe and respectful environment. Y 513 rese include:) using the least restrictive and most oppropriate settings and methods;) promoting coping and engagement dills that are alternatives to injurious behavior to alf or others;) promoting coping and engagement oil or others;) promotile providing choices of activities eaningful to the clients served/supported; and) promotile providing doming and staff.) the secompanied by actions designed to sure dignity and respect during and after the tervention. These include:) using the intervention by people ained in its use. and respectful environment his Rule is not met as evidenced by: ased on interview and record review, the facility iled to ensure a respectful environment fecting 5 of 5 audited former clients (Former lients #1, #2, #3, #4, and #5). The findings are: eview on 8/11/20 and 8/12/20 of Former Client ['s record revealed: Visitary end Josensed with Disruptive Mood Dysregulation Isorder and Attention Deficit Hyperactivity isorder; Joganosed with Disruptive Mood Dysregulation Isorder and Attention Deficit Hyperactivity ased on interview and 8/12/20 of Former Client ['searord]

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			SURVEY PLETED
			A. BUILDING:			
		MHL036-336	B. WING		09	/29/2020
iame of Pi	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		NTINGTON DRIVE NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 513	Continued From page 117		V 513			
	and Attention Deficit -9 years old. Review on 8/11/20 a #3's record revealed -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atten Disorder, Post Traum	t Traumatic Stress Disorder Hyperactivity Disorder; nd 8/12/20 of Former Client				
	#4's record revealed -Admitted 4/24/20; -Discharged 8/6/20;	oositional Defiant Disorder				
	#5's record revealed -Admitted 8/5/20; -Discharged 8/7/20; -Diagnosed with Pos	t Traumatic Stress Disorder, sregulation Disorder, and				
	revealed: -"One day [Staff # hands on my throat b was in the van at [Si remember who was	vith Former Client #3 8] got really mad and put her out did not really choke me. I ster Facility A]Cannot driving the van;" Former Client #3 "b***h				

S6LM11

If continuation sheet 118 of 132

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START					
			NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
V 513	Continued From page	e 118	V 513			
	fatstinkyp***y #3"could not stop ru	" and said Former Client Inning her mouth"				
	Department of Social revealed:	with Former Client #3's Services Social Worker				
	Client #3 on 8/4/20, F	acility to pick up Former Former Client #3 was in the e staff member who had				
	revealed:	with Former Client #4 ds around Former Client #3's oke her:				
	-The incident occurre Facility A;	d on the driveway of Sister Client #3 were cursing at				
	-Former Client #3 late because she liked St	er denied the incident aff #8; er Client #3 "a b***h				
	-Licensee #2/Executi	al DSS worker a "b***h;" ve Director, Staff #5, Staff #12 had all cursed at				
	Former Client #4;	not allowed out of their				
	Social Worker reveal	with Former Client #4's DSS ed: aming and staff speaking				
		with Former Client #4;				
	revealed:	with Former Client #5				
	would pull her shirt a	to Former Client #1. They nd drag her to her room. really didn't do nothingthey				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
RESH NE	EW START		INTINGTON DRIVE			
			NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 513	Continued From page	e 119	V 513			
	room;	entlythey put her in her our bedrooms all the time"				
	-Denied witnessing s former clients;	with Staff #5 revealed: taff put their hands on any taff curse at any former				
		with Staff #8 revealed: ands around Former Client				
	revealed:	with Former Staff #12 Staff #8 choke Former Client				
	-Denied cursing at ar	ny former clients; taff curse at any former				
	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment.	Professional #1 and				
		ss referenced into 10A ope (V293) for a Type A1				
V 536	27E .0107 Client Rig Int.	hts - Training on Alt to Rest.	V 536			
	10A NCAC 27E .010 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall im practices that empha	RESTRICTIVE				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-336	B. WING				
	ROVIDER OR SUPPLIER		B. WING 09/29/202 EET ADDRESS, CITY, STATE, ZIP CODE 09/29/202				
			INTINGTON DRIVE				
FRESH NI	EW START	GASTO	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 536	Continued From pag	e 120	V 536				
	disabilities, staff incluer employees, students demonstrate competer completing training in other strategies for completing training in other strategies for complexity of a person of property damage is provider wishes to determine the Division of MH/D paragraph (g) of this (g) Staff shall demons following core areas: (1) knowledge people being served; (2) recognizing external stressors that disabilities; (4) strategies for relationships with performance is property damage is property	a services to people with ading service providers, or volunteers, shall ence by successfully a communication skills and reating an environment in of imminent danger of abuse with disabilities or others or orevented. s shall establish training etencies, monitor for internal onstrate they acted on data be competency-based, earning objectives, written and by observation of bjectives and measurable e passing or failing the training must be completed ider periodically (minimum ining that the service nploy must be approved by D/SAS pursuant to Rule. and understanding of the					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL036-336			09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
FRESH NE	EW START		NTINGTON DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
V 536	Continued From pag	e 121	V 536				
	disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in ass escalating behavior; (8) communica and de-escalating po and (9) positive bel means for people with activities which direct behaviors which are (h) Service providers documentation of init at least three years. (1) Documentat (A) who particip outcomes (pass/fail); (B) when and y (C) instructor's (2) The Division review/request this d (i) Instructor Qualifier Requirements: (1) Trainers sho	eessing individual risk for ation strategies for defusing tentially dangerous behavior; havioral supports (providing h disabilities to choose tly oppose or replace unsafe). s shall maintain ial and refresher training for ation shall include: bated in the training and the where they attended; and name; n of MH/DD/SAS may ocumentation at any time.					
	need for restrictive in (2) Trainers sh by scoring a passing instructor training pro (3) The training competency-based, i objectives, measurate observation of behave	all demonstrate competence grade on testing in an ogram.					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MUI 026 226	B. WING			
	ROVIDER OR SUPPLIER	MHL036-336	DDRESS, CITY, STATE,		08	0/29/2020
NAIVIE OF PI	ROVIDER OR SUPPLIER			ZIP CODE		
RESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 536	service provider plana approved by the Divis to Subparagraph (i)(5 (5) Acceptable shall include but are in (A) understandi (B) methods for course; (C) methods for performance; and (D) documentat (6) Trainers sh teaching a training pri reducing and elimination interventions at least review by the coach. (7) Trainers sh aimed at preventing, need for restrictive in annually. (8) Trainers sh instructor training at I (j) Service providers documentation of initit training for at least th (1) Docume	t of the instructor training the s to employ shall be sion of MH/DD/SAS pursuant 5) of this Rule. instructor training programs not limited to presentation of: ng the adult learner; r teaching content of the or evaluating trainee tion procedures. all have coached experience ogram aimed at preventing, ting the need for restrictive one time, with positive all teach a training program reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain ial and refresher instructor	V 536			
	 (C) instructor's (2) The Division request and review th (k) Qualifications of C (1) Coaches sharequirements as a transmission of the second second	where attended; and name. n of MH/DD/SAS may nis documentation any time. Coaches: nall meet all preparation niner.				
	the course which is b	nall teach at least three times eing coached. nall demonstrate				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		MHL036-336			09	/29/2020
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
RESH NE	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From pag	e 123	V 536			
	train-the-trainer instru	oletion of coaching or uction. nall be the same preparation				
	failed to ensure staff to restrictive interven	as evidenced by: and record review, the facility were trained in alternatives tions affecting 1 of 10 rs (Staff #6). The findings				
	#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be				
	revealed: -Not a good time for was working at her o	Dayz (Licensee/Sister Facility				
	#6 was unsuccessful the mailbox was full.	9/11/20 at 2:10pm with Staff I. There was no answer and A text message was sent to hich was read at 2:12pm. A				

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
		MHL036-336	6 B. WING		09/29/2020			
NAME OF P	ROVIDER OR SUPPLIER		TADDRESS, CITY, STATE, ZIP CODE					
			NTINGTON DRIVE					
FRESH NI	EW START	GASTON	NIA, NC 28056					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
V 536	Continued From page	e 124	V 536					
	DHSR surveyor cont	ges between Staff #6 and the inued and Staff #6 was be contacted as needed.						
	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment.	Professional #1 and						
	•	ss referenced into 10A ope (V293) for a Type A1						
V 537	27E .0108 Client Rig ITO	hts - Training in Sec Rest &	V 537					
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to em procedures are retrain competence at least (b) Prior to providing disabilities whose tree includes restrictive in service providers, em volunteers shall comp seclusion, physical re and shall not use the training is completed demonstrated. (c) A pre-requisite for	ICAL RESTRAINT AND UT cal restraint and isolation bloyed only by staff who have we demonstrated roper use of and alternatives Facilities shall ensure that inploy and terminate these ined and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including inployees, students or plete training in the use of estraint and isolation time-out se interventions until the						

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 125 of 132

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, Z		03	5/29/2020
			INTINGTON DRIVE			
FRESHIN	EW START	GASTO	NIA, NC 28056			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	e 125	V 537			
	include measurable la measurable testing (w behavior) on those of methods to determine course. (e) Formal refresher by each service provi- annually). (f) Content of the tra provider plans to emp the Division of MH/DI Paragraph (g) of this (g) Acceptable trainin- but are not limited to, (1) refresher in the use of restrictive (2) guidelines of (understanding immin- others); (3) emphasis of rights and dignity of a concepts of least rest- incremental steps in a (4) strategies fr of restrictive interven (5) the use of e- interventions which ir assessment and mor psychological well-be- use of restraint through restrictive intervention (6) prohibited p (7) debriefing s- importance and purp- (8) documentar	be competency-based, earning objectives, written and by observation of bjectives and measurable e passing or failing the training must be completed ider periodically (minimum ining that the service oloy must be approved by D/SAS pursuant to Rule. ng programs shall include, presentation of: formation on alternatives to interventions; on when to intervene nent danger to self and on safety and respect for the all persons involved (using trictive interventions and an intervention); or the safe implementation tions; emergency safety nclude continuous nitoring of the physical and eing of the client and the safe ghout the duration of the n; procedures; strategies, including their ose; and tion methods/procedures.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON			E SURVEY PLETED
	of correction	IDENTIFICATION NUMBER.	A. BUILDING:			
		MHL036-336	MHL036-336 B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZI	P CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	e 126	V 537			
	 (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this defined (i) Instructor Qualific Requirements: (1) Trainers shing scoring 100% on the aimed at preventing, need for restrictive in (2) Trainers shing scoring 100% on the teaching the use of sea and isolation time-out (3) Trainers shing scoring a passing instructor training prot (4) The training competency-based, in objectives, measurable observation of behave measurable methods failing the course. (5) The content service provider plant approved by the Divist to Subparagraph (j)(6) (6) Acceptable shall include, but not of: (A) understandii (B) methods for course; 	where they attended; and name. n of MH/DD/SAS may ocumentation at any time. ation and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. all demonstrate competence testing in a training program eclusion, physical restraint t. all demonstrate competence grade on testing in an ogram. g shall be nclude measurable learning ble testing (written and by ior) on those objectives and to determine passing or t of the instructor training the s to employ shall be sion of MH/DD/SAS pursuant b) of this Rule. instructor training programs be limited to, presentation ng the adult learner; r teaching content of the				
		of trainee performance; and tion procedures.				

Division of Health Service Regulation STATE FORM

6899

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MHL036-336			09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
FRESH N	EW START	4460 HU	NTINGTON DRIVE			
		GASTON	NA, NC 28056			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From page	e 127	V 537			
	annually and demons of seclusion, physical time-out, as specified Rule. (8) Trainers shi CPR. (9) Trainers shi in teaching the use of least two times with a coach. (10) Trainers shi use of restrictive inter annually. (11) Trainers shi instructor training at I (k) Service providers documentation of initi training for at least th (1) Documenta (A) who particip outcome (pass/fail); (B) when and v (C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches shi requirements as a trai (2) Coaches shi	a shall maintain ial and refresher instructor ree years. tion shall include: bated in the training and the where they attended; and name. n of MH/DD/SAS may occumentation at any time. Coaches: hall meet all preparation tiner. hall teach at least three ich is being coached. hall demonstrate oletion of coaching or luction. shall be the same				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-336	B. WING		00/00/0000	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		09	/29/2020
			INTINGTON DRIVE			
RESHINE	EW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 537	Continued From page	e 128	V 537			
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were trained in seclusion, physical restraint and isolation time-out affecting 1 of 10 audited staff members (Staff #6). The findings are:					
	#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be				
	revealed: -Not a good time for a was working at her o	Dayz (Licensee/Sister Facility				
	Attempted interview 9/11/20 at 2:10pm with Staff #6 was unsuccessful. There was no answer and the mailbox was full. A text message was sent to the phone 2:11pm which was read at 2:12pm. A series of text messages between Staff #6 and the DHSR surveyor continued and Staff #6 was informed she would be contacted as needed.					
	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment.	Professional #1 and				
	This deficiency is cro	ass referenced into 10 A				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
FRESH NE	EW START		INTINGTON DRIVE NIA, NC 28056			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
V 537	Continued From page	e 129	V 537			
	NCAC 27G .1701 Sc rule violation.	ope (V293) for a Type A1				
V 541 27F .0104 Client Rig Cloth/Poss		hts - Stor. & Protect of	V 541			
	protect each client's possessions from the loss, and misplaceme limited to, assisting the maintaining an invent					
	failed to protect client affecting 3 of 5 audite Clients #1, #3, and # Finding #1 Review on 8/11/20 ar #1's record revealed:	nd record review, the facility ts' personal possessions ed former clients (Former 4). The findings are: nd 8/12/20 of Former Client				
		uptive Mood Dysregulation n Deficit Hyperactivity				
	revealed:	with Former Client #1 ronic tablet was not returned				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MUL 026 226	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	MHL036-336	ADDRESS, CITY, STATE	09	/29/2020	
	EW START		INTINGTON DRIVE			
		GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 541	Continued From page	e 130	V 541			
	to her upon discharge	e from the facility.				
	Interview on 9/3/20 with Former Client #1's Department of Social Services (DSS) Social Worker revealed: -Former Client #1 still has not received her electronic tablet from the facility despite requests. Review on 9/4/20 of Email Correspondence from Former Client #1's DSS Social Worker dated 9/4/20 at 2:52pm to Division of Health Service Regulation Surveyor revealed: -Former Client #1's electronic tablet was finally returned (29 days after discharge).					
	#3's record revealed: -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atte Disorder, Post Traum	nd 8/12/20 of Former Client ntion Deficit Hyperactivity natic Stress Disorder, Disorder, Depression;				
	Social Worker reveal -Upon discharge, For provided with her P-E Benefit Transfer) card the facility on 7/21/20 30-day notice of disc -Called Food Stamps canceled the card an	rmer Client #3 was not EBT (Pandemic Electron d. The card was pinned by) after the facility had given a harge for Former Client #3;				
	Finding #3 Review on 8/11/20 a #4's record revealed: alth Service Regulation	nd 8/12/20 of Former Client				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT IDENTIFICATION NUMBER: A. BUILDING:				TE SURVEY	
			B. WING				
	ROVIDER OR SUPPLIER	MHL036-336	B. WING 09/29/				
FRESH NE	EW START	GASTO	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 541	Continued From pag	e 131	V 541				
	-Admitted 4/24/20; -Discharged 8/6/20; -Diagnosed with Opp and Unspecified Trat -13 years old;	positional Defiant Disorder uma;					
	revealed: -Had a cell phone wh -Licensee #2/Execut -A clothing voucher r #2/Executive Director Worker; -The clothing voucher early July; -Former Client #4 wa never received the cl	with Former Client #4 nen she moved to the facility; ive Director took the phone; made out to Licensee or was sent by her DSS Social er was sent in late June or as never taken shopping and lothing voucher money.					
	Social Worker reveal	clothing money was never					
	Client #4's DSS Soci #4 she could not kee taken away and mail biological mother; -Licensee #2/Execut	Professional #1 and					
		oss referenced into 10A cope (V293) for a Type A1					