	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL036-336	B. WING		09/29/2020
FRESH NE	ROVIDER OR SUPPLIER  EW START	4460 HU GASTO	ADDRESS, CITY, STAT JNTINGTON DRIVI NIA, NC 28056	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	A complaint survey wa 29, 2020. The complaid (Intake #NC168184). If This facility is licensed category: 10A NCAC at Treatment Staff Secur Adolescents.  A sister facility is identified us and a numerical identified us and a numerical identified with only a numerical identified interviews, it was establishared between facilities. Throughout the survey including the exit confestaff continued to be distributed in the survey including the exit confestaff continued to be distributed in the survey including the survey including the survex Regulated eventually identified. Moreonated to the survey. The phone call on 8/10/20 and via email to both license of the survey. The phone call on 8/10/20 are eventually received via 5:00pm and was review revealed "No former standiscovered that multiple were not voluntarily reported in interviews, but the namembers were not iden	is completed on September int was unsubstantiated Deficiencies were cited.  If or the following service 27G .1700 Residential e for Children or  fied in this report. The das Sister Facility A. Sing the letter of the facility iter. All staff are referred to dentifier. Through multiple blished that staff were es.  process, up to and rence, current and former scovered by the Division of ion (DHSR) surveyor and builtiple requests were made and former staff at the erequests were made via the approximately 10:30 am ensees on 8/10/20 at 10:17 am. A staff list was fax on 8/12/20 after red on 8/13/20. The list ff." During survey, it was current and former staff orted by either licensee to less staff were discussed	V 000	DHSR-Mental Health Mark () / 2020 Lic. & Cert. Section	

Division of Health Service Regulation

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

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY	
		MHL036-336	B. WING		09/2	29/2020	
	ROVIDER OR SUPPLIER	4460 H	ADDRESS, CITY, SUNTINGTON DO	RIVE	1 30/2		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 0000	8/27/20 at 11:12am remembers be identified they did not know the 8/27/20, DHSR non-d from previous surveys Staff #11/Former Clie Former Staff #12 were was identified as Staff occurred when Licens revealed in an email of Staff #6 was on-site at 7/31/20, 8/1/20, and 8 Department of Social Facility A and that it with the safety plan for Sist Licensee #2/Executive was only working for of training. An additional identified during exit. L Director revealed she cheeded to be identified	equested these staff d. The licensees reported individuals in question. On isclosed documentation is was reviewed. Former int #A2's Grandmother and is identified. A female staff if 6. This identification ee #2/Executive Director in 9/3/20 at 12:31pm that is Sister Facility A on isclosed documentation is was reviewed. Former int #A2's Grandmother and is identified A female staff if 6. This identification ee #2/Executive Director in 9/3/20 when the local Services arrived at Sister is Staff #6's signature on er Facility A. Interview with is Director revealed Staff #6 ine week and was still employee, Staff #10, was icensee #2/Executive	V 000	V108			
	<ul><li>(g) Employee training provided and, at a mirthe following:</li><li>(1) general organization</li><li>(2) training on client ridelineated in 10A NCA 10A NCAC 26B;</li><li>(3) training to meet the</li></ul>	PERSONNEL  Ideation shall be documented.  programs shall be  programs shall be  programs shall consist of  programs and consist of  programs shall be  programs shall be  programs shall be  programs shall be  programs and consist of  progra	V 108	The agency will comply with all requiren 10A NCAC 27G .0202 including the requirent that all staff are trained in:  ;  1. general organizational orientation orientation of the standard orientation or standard orientation or standard orientation or standard or standard orientation o	on 10A 10A	10/22/220	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. BOILDIN				
		MHL036-336	B. WING		09/:	29/2020	
	ROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE			
FRESH N	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 108	27G .5602(b) of this staff member shall be all times when a clier member shall be train including seizure man to provide cardiopulm trained in the Heimlic aid techniques such a Cross, the American equivalence for reliev (i) The governing bod implement policies an identifying, reporting, infectious and commupersonnel and clients.  This Rule is not met a on interview, record in the facility failed to en	rmitted under 10a NCAC Subchapter, at least one e available in the facility at at is present. That staff ned in basic first aid nagement, currently trained nonary resuscitation and h maneuver or other first as those provided by Red Heart Association or their ring airway obstruction. y shall develop and d procedures for investigating and controlling unicable diseases of	V 108	V108 Con't  4. training in human sexuality or aggressive youth.  5. training in client specific treatr plans.  6. First aid/CPR.  7. Medication Administration  8. Alternative to seclusion and rei.e. CPI.  Specifically, the agency will require all scomplete the above competency-based above prior to starting work.  To ensure compliance with this standar agency will contract with a Certified For Health Care Auditor* for three months to agency to sure compliance with POC. The self-audits will be in record.  2. Consult with leadership about compliance matters.	ment estraint staff to d trainings rd the rensic o: of the th this		
	#1, Licensee #2/Exec Professional, Staff #4	r/Qualified Professional cutive Director, Associate 4, Staff #5, Staff #6, Staff 2 of 2 audited former 1/ Former Client #2's		<ol> <li>Consult with Client Rights Beh Intervention Committee</li> <li>Conduct training with staff about POC prior to the staff working, initial training will be live or live The initial training will be record available to playback for future hires and annual retraining.</li> </ol>	ut this The conline.		
	Review on 8/11/20, 8/ of Former Client #1's i -Admitted 12/27/19; -Discharged 8/6/20;			See last page for Certified Forensic Hea Auditor credentials	ilth Care		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09.	/29/2020
	ROVIDER OR SUPPLIER	MHL036-336  MHL036-336  STREET ADDRESS, CITY, STATE, ZIP CODE  4460 HUNTINGTON DRIVE  GASTONIA, NC 28056  TEMENT OF DEFICIENCIES  IT MUST BE PRECEDED BY PILL  SCIDENTIFYING INFORMATION)  PREFIX  TAG  TO PREFIX  TAG  TO PREFIX  TAG  PREFIX  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY,  Application revealed  88; Thom the rapist: Walking as a drug attic, mental  uld set her in the swing  lized behaviors in the  2/20 and 8/18/20 of rd revealed:  traumatic Stress Disorder peractivity Disorder;  7/11/20 revealed Former an sexually molested at the  2/20 and 8/18/20 of rd revealed:  traumatic Stress Disorder,  on Deficit Hyperactivity  on				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES	DBE	COMPLETE
	-Diagnosed with Disrudisorder and Attention Disorder; -11 years old; -Undated Residential a history of sexual abit-Initial Assessment of #1/Director/Qualified 12/26/19 revealed: ". ball of trauma. Mom whealth issues. Mom wall day. Possible sexuipast"  Review on 8/11/20, 8/Former Client #2's red-Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Post and Attention Deficit H-9 years old; -Treatment plan updat Client #2 may have be age of 5 or 6 years old Review on 8/11/20, 8/Former Client #3's red-Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Attent Disorder, Post Trauma Oppositional Defiant D 13 years old; -Undated Residential Ahistory of sexually inapincreased sexualized gotten older and freque Historical information frequences.	Application revealed use; ompleted by the Licensee Professional #1 datedFrom therapist: Walking was a drug attic, mental rould set her in the swing alized behaviors in the 12/20 and 8/18/20 of ford revealed:  Traumatic Stress Disorder lyperactivity Disorder; er 7/11/20 revealed Former ten sexually molested at the  12/20 and 8/18/20 of ford revealed:	V 108			

Division of Health Service Regulation

STATE FORM 6899 S6LM11 If continuation sheet 4 of 132

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY
		MHL036-336	B. WING		09/:	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
EDECLIN	EW START	4460 HI	UNTINGTON DRIVI	E		
FRESHIN	EWSTART	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 108	Continued From page	ge 4	V 108			
	is not able to maintai and will touch others Client feels that this i -Discharge Summary #1/Director/Qualified 8/4/20 revealed: "s was filed against cliet Comprehensive Clini addendum completed Professional/Qualified 8/17/20 revealed: " boundaries and she tinappropriately often hugging without perm Review on 8/11/20, sof Former Client #4's -Admitted 4/24/20; -Discharged 8/6/20; -Diagnosed with Opp and Unspecified Trau-13 years old; -Initial Assessment of	d Professional #2 dated thas no understanding of ouches people rubbing on them and hission"  8/12/20 and 8/18/20 s record revealed: ositional Defiant Disorder ima;				

Division of Health Service Regulation

#1 dated 4/23/20 revealed: "...[Former Client #4] was caught kissing her room mate in

-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 inappropriate behaviors and " ...[Former Client #4] makes sexual comments to peers and

-Treatment plan dated 8/6/20 revealed Former Client #4 was discharged due to being the alleged perpetrator of a sexual assault allegation

previous placements..;"

displays sexual gestures ...;"

involving another peer;

STATE FORM S689 S6LM11 If continuation sheet 5 of 132

	er realiti e er riee i toge	TOTTOTT				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	MULTIPLE CONSTRUCTION BUILDING:		TE SURVEY MPLETED
		MHL036-336	B. WING			0/29/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIR CODE	09	112912020
			UNTINGTON DRIV			
FRESHN	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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	Review on 9/8/20 and #1/Director/Qualified Frevealed: -Hire date not recorde -No documentation of sexuality, sexually agg trauma; -No document specific treatment plantarianed himself in the MH/DD/SAS (Mental Fibiability/Substance A 2/8/18, Person Center Health and Safety date Competency dated 2/1 Confidentiality dated 2 Management and Plantariane Review on 9/8/20 of Initivith Division of Health (DHSR) for the facility in Licensee #1/Director/of #1 was identified on the licensure dated 12/30/1 issued on 4/10/20.  Review on 9/8/20 of Initivith DHSR for Sister Falciensee #1/Director/Off was identified on the apand on the license issued Review on 9/8/20 and 9/8/2/Executive Director's Hire date of 8/1/18; -No documentation of the sexually aggressive your specific products of the sexually aggressive your second of the seco	9/9/20 of Licensee Professional #1's record d; training in human gressive youth, or sexual tation of training in client as; following topics: Health/Developmental buse Services) dated ed Thinking dated 2/7/18, ed 2/9/18, Cultural 0/18, Rights and //11/18, and Crisis uning dated 2/10/18.  tial Licensure Application Service Regulation revealed: Qualified Professional e application for initial 19 and on the license  ial Licensure Application acility A revealed: - ualified Professional #1 plication dated 5/14/18 ed on 6/13/18.  3/9/20 of Licensee record revealed: raining in human sexuality, uth, or sexual trauma; raining in client specific	V 108			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL036-336	B. WING		09/	/29/2020
	PROVIDER OR SUPPLIER	4460 HU	NDDRESS, CITY, STATE NTINGTON DRIVINIA, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
	record revealed: -Hire date of 7/1/19; -No documentation of sexually aggressive young of treatment plans.  Review on 9/9/20 of Substitution of treatment plans.  Review on 9/9/20 of Substitution of treatment plans.  Review on 9/9/20 with treatment plans.  Attempted review on 9/9/20 with treatment plans of the records were sent #1/Director/Qualified Publicensee #2/Executive 9:53am for the records again on 9/8/20 at 1:34 sent via secured and entire treatment plans.	training in human sexuality, buth, or sexual trauma; training in client specific taff #4's record revealed: training in human sexuality, buth, or sexual trauma; -No ing in client specific  Staff #5 revealed:  Training in human sexuality, buth, or sexual trauma; raining in human sexuality, buth, or sexual trauma; raining in client specific  14/20 and 9/8/20 of Staff becessful as no records for review. Requests for the buto Licensee for review. Requests for the buto be sent via fax and pum for the records to be corrypted email.  18/9/20 of Staff #8's record fraining in human sexuality, buth, or sexual trauma;	V 108			

Division of Health Service Regulation

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING.	(X3) DATE SURVEY COMPLETED		
		MHL036-336	B. WING		00/00	/2022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	TE 710 CODE	09/29	/2020
EDECLIN	EW START		JNTINGTON DRIVI			
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	Continued From page	e 7	V 108			
	sexually aggressive y	e); f training in human sexuality, outh, or sexual trauma; f training in client specific				
	Client #2's Grandmoth -No hire date recorded -No documentation of sexually aggressive yo					
	revealed: -Hire date of 6/4/20; -No documentation of sexually aggressive yo	ormer Staff #12's record  training in human sexuality, buth, or sexual trauma; training in client specific				
- - - -	revealed: -Could not recall all the Sexualized behaviors v meetings but never had deal with sexualized be	d any training on how to ehaviors; I any additional trainings				
1	insuccessful. A phone	call back. No call was ever				
a	nterview/Observation on approximately 2:15pm v					

STATE FORM

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		TE SURVEY MPLETED	
		MHL036-336	B. WING		09	9/29/2020	
	ROVIDER OR SUPPLIER	4460 HU	ADDRESS, CITY, STAT JNTINGTON DRIVI NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE	
V 108	orientation but could n discussed during the tridentify what "groomin sexualized behaviors; -Did not respond whom individualized treather behaviors and the interview and heard in the backgrout to answering questions he was with someon Staff #5 denied being the interview.  Interview on 9/11/20 at #6 revealed: -Not a good time for a she was working at heard in the phone 2:11pm who series of text message DHSR surveyor continformed she would be interview on 9/11/20 without a mailbox was full. At the phone 2:11pm who series of text message DHSR surveyor continformed she would be interview on 9/11/20 without a mailbox was full. At the phone 2:11pm who series of text message DHSR surveyor continformed she would be interview on 9/11/20 without a mail treatment plans at another control of the phone at another treatment plans at another control of the phone and the phone at another control of the phone and th	alized behaviors during of identify what was raining and could not g" was in relation to en asked about training tment plans; ne on speaker phone and whispering could be and. Staff #5 hesitated prior as. Staff #5 was asked if the else during the interview. With anyone else during the interview with anyone else during at 12:36pm with Staff an interview because er other job; ayz (Licensee/Sister of call me at 2(pm)."  In 1/20 at 2:10pm with Staff and the interview and at ext message was sent to ich was read at 2:12pm. A is between Staff #6 and the inued and Staff #6 was contacted as needed.  In Staff #8 revealed: In Staff #8 reveale	V 108				

Division of Health Service Regulation

STATE FORM

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
MHL036-336	B. WING	09/29/2020	
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:  A. BUILDING:	

## FRESH NEW START

4460 HUNTINGTON DRIVE

		GASTONIA, NC 28056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INFO	D BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
	Continued From page 9  -No training in sexualized behaviors; -No training in individualized treatment -Never had access to documents pertal Former Client #1; -Did not know Former Client #1's diagr  Interview on 9/25/20 with Licensee #1/Director/Qualified Professional #1 a Licensee #2/Executive Director reveale Nobody ever told them to train in individuate treatment plans or topics to meet the nether clients; -Will ensure all necessary training is conthe future.  This deficiency is cross referenced into NCAC 27G .1701 Scope (V293) for a T A1 rule violation.  27G .0203 Privileging/Training Professi 10A NCAC 27G .0203 COMPETENCIE OF QUALIFIED PROFESSIONALS AN ASSOCIATE PROFESSIONALS (a) There shall be no privileging require qualified professionals or associate profe (b) Qualified professionals and associate professionals shall demonstrate knowled and abilities required by the population s (c) At such time as a competency-based employment system is established by rule then qualified professionals and associate professionals shall demonstrate compete (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making;	ining to noses.  Ind ed: - dualized eeds of impleted in  IOA Type  Onals  V 109  S D  ments for ssionals. elde, skills erved. emaking, ee	V109 The agency will comply with all requirements of 10A NCAC 27G .0203 including ensuring the competency of the Qualified Professional. Specifically, the Qualified Professional will receive training by a qualified trainer in:  1. technical knowledge; 2. cultural awareness; 3. analytical skills; 4. decision-making; 5. interpersonal skills; 6. communication skills; and 7. clinical skills.  In addition the Qualified Professional will be trained by a qualified instructor in:  1. cultural competency 2. client rights and confidentiality 3. crisis management and planning 4. Person-Centered Planning conducting admission assessments	10/22/220

Division of Health Service Regulation

STATE FORM S6LM11 If continuation sheet 10 of 132

PRINTED: 10/15/2020 FORM APPROVED

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY	
		DENTIFICATION NUMBER.	A. BUILDIN	G:	COMPLETED	
		MHL036-336	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
FRESH N	EW START	4460 HU	JNTINGTON DE	RIVE		
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 109	NCAC 27G .0104 (18 met the requirements based employment sy for MH/DD/SAS.  (f) The governing boo develop and implement for the initiation of an implan upon hiring each at (g) The associate professional profession	s; kills; and onals as specified in 10A b)(a) are deemed to have of the competency- ystem in the State Plan by for each facility shall at policies and procedures andividualized supervision associate professional. fessional shall be ied professional with the the period of time as	V 109	V109 Con't  To ensure compliance with standards a Clinical (admission) assessments and prentered planning the agency's License Health Professional will review and appadmission assessment and person-central plans prior to implementation. The plans reviewed for completeness and clinical appropriateness.  To ensure compliance with standards at staffing the agency will maintain a databall current and former staff that includes position, date of hire and separation, are telephone number. The database will be available for inspection by DHSR.  To ensure compliance with standards are supervision the Qualified Professional we conduct documented one on one or grow supervision of Associate and Para Profe 1 time per month.	person- ed Mental prove all tered s will be  round pase of name, nd e	
	on interview, record r 2 of 2 audited current (Licensee #1/Director #1 and Licensed Prof Professional #2) and associate professional Professional) failed to	1 of 1 audited current al (Associate o display the knowledge, quired by the population are:  12/20 and 8/18/20 of oner Client #2, Former on #4, and Former ealed: s completed by the		To ensure compliance with standards are background checks to agency will conduction criminal record and healthcare registry con all staff prior to starting work. A histor record will be kept in perpetuity of all checked to ensure compliance with standards are supervision and background checks the will contract with a Certified Forensic Health and the action of the standards and approve all personnel/training records prior to staff wand at the 3 month mark.	ict hecks rical ecks. ound agency althcare	

Division of Health Service Regulation

STATE FORM S6890 S6LM11 If continuation sheet 11 of 132

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	There There was a series	E CONSTRUCTION	(X3) DATE	
7,1101,011	or connection	DENTIFICATION NUMBER.	A. BUILDING:		COMP	PLETED
			B. MINIO			
		MHL036-336	B. WING		09/2	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
FRESH N	EW START	4460 HU	NTINGTON DRI	VE		
		GASTON	IIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	Continued From pag	e 11	V 109			
		cutive Director did not				
	include presenting pre					
		or admitting diagnosis, and				
		y, and medical history; -No				
		s made available for review				
	for Former Client #2;					
		eatment plan dated 8/6/20				
		ent strategies to address				
		alized comments, anger operty destruction and				
		and the use of a summer				
	day camp;	and the use of a summer				
		eatment plan dated 7/11/20				
		ent strategies to address				
		ind desire for self-harm; -				
		atment plan dated 7/16/20				1
		ent strategies to address				
	of a summer day cam	zed behaviors, and the use				
		eatment plan dated 8/6/20				
		ent strategies to address				
		bullying, false allegations,				
	and the use of a sumn				1	
	D i 0/0/00 11					
		ssociate Professional, Staff				
	#8, and Former Staff #	te of training provided for				
	Associate Professiona					
		did not have the signature				
		o complete medication				
	administration training	j;				
	-Former Staff #12's					
	and illegible and had					
	name written on the si	ide margin.				
	Refer to 10A NCAC 27	G 0200 Modication				
	Requirements (V118) f					
	raquirements (VIII)	or apecinos.				

#1/Director/Qualified Professional #1 failed to
Division of Health Service Regulation

Interviews on 8/10/20 - 9/25/20 with Licensee

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING				
20. 27.25.20.000.070.022.0.12240.0		WITE030-330			09/	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA				
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			NIA, NC 28056				
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V 109	requests made by Regulation (DHSR) Regulation (DHSR) Finding #1 Review on 9/8/20 a #1/Director/Qualifier record revealed: -Hire date not record. No documentation sexuality, sexually a trauma; -No documentation sexuality, sexually sexuality, sexually sexuality, sexually a trauma; -No documentation sexuality, sexually sexually sexuality, s	and former staff upon the Division of Health Service and 9/9/20 of Licensee d Professional #1's  ded; of training in human aggressive youth, or sexual entation of training in client lans; the following topics: al Health/Developmental e Abuse Services) dated tered Thinking dated Safety dated 2/9/18, and Crisis lanning dated 2/10/18.  of Licensee d Professional #1's ealed: the associate arra-professionals, ncies, provision of direct services to children or pation in treatment coordination of each child ment plan, provision of ment functions"	V 109				

-Was not aware treatment strategies needed to Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL036-336	B. WING	09/29/2020

STREET ADDRESS, CITY, STATE, ZIP CODE

## FRESH NEW START

## 4460 HUNTINGTON DRIVE 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 13  be developed and implemented to address the needs of the former clients; -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 although evidence was contradictory; -Denied there was lack of privacy 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 training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint and Isolation	V 109		
	Time-Out for Staff #6.  Finding #2 Review on 9/8/20 and 9/9/20 of the Licensed Professional/Qualified Professional #2's record revealed: -Licensed as a Clinical Mental Health Counselor.  Interview/Observation on 9/10/20 at			
	approximately 2:45pm - 3:10pm with Licensed Professional/Qualified Professional #2 revealed:			

Division of Health Service Regulation

STATE FORM

S6LM11

6890

If continuation sheet 14 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF 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 PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### FRESH NEW START

# 4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE		
V 109	Continued From page 14  -Employed at the facility and Sister Facility A since 2017; -Provided individual and group therapy twice weekly; -Used virtual sessions during the start of the pandemic and resumed face to face sessions in the beginning of July; -Last time at Sister Facility A was 9/2/20 when she saw Former Client #2 who was the only client at the facility; -Upon confirming with the Licensed Professional/Qualified Professional #2 that the last date of service was 9/2/20 to Former Client #2, the call was suddenly disconnected at 2:50pm; -Return calls to the Licensed Professional/Qualified Professional #2's phone made immediately upon disconnection of the call went to voicemail and a message was left requesting a return call; -Call was returned by the Licensed Professional/Qualified Professional #2 at 2:57pm who reported her cell phone battery went dead; -During the return call, the Licensed Professional/Qualified Professional #2 revealed she made a mistake and did not view her calendar correctly during the initial call. The last date of service at the facility was 8/2/20 when Former Client #2 was the only client at Sister Facility A; -Will send copies of Licensed Professional #2's notes via a secured and encrypted email for all clients	V 109		DATE		
	9/10/20.  Based upon record reviews of Former Clients #1, #2, #3, #4, and #5 and their respective discharge dates, there were no clients in the facility on 9/2/20 although the Licensed					

Division of Health Service Regulation

STATE FORM 6899 S6LM11 If continuation sheet 15 of 132

PRINTED: 10/15/2020 FORM APPROVED

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			20125110.				
		MHL036-336	B. WING		09/29/	2020	
NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE			
FRESH NE	EW START	4460 HI	JNTINGTON DRIVI	E			
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V 109	Continued From pag	ge 15	V 109				
	identified this as the aforementioned recording that Former Clients appresent in the facility Licensed Profession identified only Former Review on 9/11/20 or to DHSR surveyor for Professional/Qualifie 9/10/20 at 6:54pm re "Good evening, I'm work and do not forest requested documental will have this informatical will have this informatical recording in the second r	d Professional #2 dated evealed: anted 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					
	to DHSR surveyor from Professional/Qualified 9/11/20 at 8:09pm revocational notes on Form #4 (Former Client #5 with wood ays) were sent viscure and encrypted -No documentation of to Former Clients #A1 Interviews on 8/12/20 Clients #1, #2, #3, and	d Professional #2 dated vealed: mer Clients #1, #2, #3 and was only at the facility for ia an attachment to a email; of clinical services provided I, #A2, #A3, and #A4.  - 9/14/20 with Former d #4 revealed: -The I/Qualified Professional					
	Interview on 9/25/20 v #1/Director/Qualified I Licensee #2/Executive Service Regulation	Professional #1 and					

STATE FORM S6LM11 If continuation sheet 16 of 132

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
FRESH N	EW START	4460 H	UNTINGTON DRIV	E		
		GASTO	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
	Sessions were cond start of the pandemi person sessions.  Finding #3 Review on 9/9/20 of record revealed: -Hire date of 7/1/19.  Review on 9/14/20 or Job Description reversions included: "I day operations of the direct care staff regar to the implementation adolescent's treatmer service planning mee assessment and progreen/parents which in and needs of client, s review of medications of assessment and coagencies. Participate Individualized Treatment Interview on 9/21/20 vervealed: -Worked as Associated-Filled in as Qualified -Sexualized behaviors meetings but never had deal with sexualized because he worked for Social Services; -Not sure how often of	essional/Qualified s at the facility weekly. Inceed virtually during the c and then returned to in-  Associate Professional's  If Associate Professional's  aled: Management of the day to group home, supervision of ding responsibilities related of each child or at plan, participation in tings, conduct initial aram orientation session with cludes identifying strength trengths and needs of family, s, assessment of scheduling ontact with collateral in development of new ent Plans"  with Associate Professional  a Professional; Professional as needed; s were discussed during ad any training on how to behaviors; ed any additional trainings or a local Department of  ar when the clients	V 109			
	-Did not feel he neede because he worked fo Social Services;	ed any additional trainings or a local Department of or when the clients as from the Licensed				

Division of Health Service Regulation

STATE FORM S6890 S6LM11 If continuation sheet 17 of 132

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	LE CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING	2.	1	LLILO
		MHL036-336	B. WING		09/2	9/2020
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FRESH NE	EW START	4460 HU	NTINGTON DR	RIVE		
		GASTON	IIA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	Continued From page	e 17	V 109	V110		10/22/220
V 110	-Phone calls were surformer clients place of for staff to listen to the This deficiency is crowdered. This deficiency is crowdered to the This deficiency is crowdered. The transfer of the This deficiency is crowdered to the transfer of the This deficiency is crowdered. The transfer of the This deficiency is crowdered to the transfer of the This deficiency is crowdered. The transfer of the This deficiency is crowdered to the This deficiency is crowdered to the This deficiency is crowdered. The This deficiency is crowdered to the This deficiency is crowdered to the This deficiency is crowdered to the This deficiency is crowdered. The This deficiency is crowdered to the This d	pervised by having the calls on speaker phone e calls.  ss referenced into 10A ope (V293) for a Type  upervision  COMPETENCIES AND ARAPROFESSIONALS privileging requirements  shall be supervised by onal or by a qualified iied in Rule .0104 of this shall demonstrate abilities required by competency-based established by rulemaking, onals and associate monstrate competence. be demonstrated including:  ge; ge;	V 110	The agency will comply with all requirer 10A NCAC 27G .0202 including the required that all staff are trained in:  ;  1. general organizational orientat 2. training on client rights and confidentiality as delineated in NCAC 27C, 27D, 27E, 27F and NCAC 26B.  3. training to meet the mh/dd/sa right the client as specified in the treatment/habilitation plan.  4. training in infectious diseases a bloodborne pathogens  5. training in human sexuality or saggressive youth.  6. training in client specific treatming plans.  7. First aid/CPR.  8. Medication Administration  9. Alternative to seclusion and reside. CPI.  Specifically, the agency will require all straining in complete the above competency-based above prior to starting work.  To ensure compliance with standards are supervision and background checks the will contract with a Certified Forensic Healthcare Auditor to review an approve all personnel/training records pristaff working and at the 3 month mark.	ion 10A d10A needs of and sexually ent straint taff to trainings ound agency ind ior to	10/22/220
	(f) The governing body develop and implement	t policies and procedures andividualized supervision		When the Certified Forensic Health Care contract expires a qualified agency staff assume the duties of monitoring complianthis POC. The Certified Forensic Health Auditor will train his replacement in standard audit practices.	will nce with Care	

Division of Health Service Regulation

STATE FORM S6899 S6LM11 If continuation sheet 18 of 132

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY PLETED
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	ROVIDER OR SUPPLIER	4460 HI	ADDRESS, CITY, S JNTINGTON DI NIA, NC 28056			
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	on interview and recor audited current parapr #2/Executive Director) knowledge, skills, and the population served.  Review on 9/8/20 and #2/Executive Director's -Hire date of 8/1/18; -Did not ensure necess needs of the clients.  Review on 9/14/20 of L Director's Job DescriptiAdministrators supen residential group home hiring, orientations and communication within the ensure compliance with maintain positive profess assist in the development participate in treatment 24/7 based on the progractively participate in arwith other supervisors/ryour own career and de agency directors, provict training to employees bon all program models/g	s evidenced by: Based of review, 1 of 7 ofessionals (Licensee of failed to display the abilities required by The findings are:  9/9/20 of Licensee of record revealed:  sary training to meet the of the same of t	V 110	V 110 Con't  To ensure compliance with standards admission assessments and person-ceplanning the agency's Licensed Menta Professional will review and approve a admission assessment and person-ceplans prior to implementation. The plan reviewed for completeness and clinica appropriateness.	entered al Health all ntered ns will be	

1		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	THE SECOND CONTRACTOR OF THE PROPERTY OF THE P	CONSTRUCTION		E SURVEY	
	71101011	or connection	IDENTIFICATION NOIVIBER.	A. BUILDING:		COV	MPLETED	
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	NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA				
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	V 110	Continued From pag	e 19	V 110				I
	V 110	utilize problem solvir emergency situations on the QA/QI (Qualit Improvement) commas Intervention Advis fatalities"  Review on 8/11/20, 8 Former Client #1, Fo Client #3, Former Client #1, Fo Client #5's records re-The initial assessment Licensee #1/Director/and Licensee #2/Exectinclude presenting prostrengths, provisional and pertinent social, from initial assessment review for Former Client #1's transfer wiew for Former Client #1's transfer outbursts include address hygiene issuanger outbursts include and physical aggress summer day camp; -Former Client #2's tredid not include treatmer property destruction ar Former Client #3's treatid not include treatmer running away, sexualized a summer day camp; -Former Client #4's tredid not include treatmer client #4's tredid #4's tredid not include treatmer client #4's tredid not include t	ng skills to manage s/disaster plan review, sit y Assurance/Quality ittee, client rights as well sory committee, review all sory commer client #2, Former ent #4, and Former evealed: Into completed by the Qualified Professional #1 cutive Director did not oblems, needs and or admitting diagnosis, amily, and medical history; the was made available for ent #2; eatment plan dated extreatment strategies to es, sexualized comments, ding property destruction ion, and the use of a seatment plan dated 7/11/20 ent strategies to address and desire for self-harm; - atment plan dated 7/16/20 ent strategies to address and behaviors, and the use	V 110				
		#8, and Former Staff #	ssociate Professional, Staff					

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
MHL036-336	B. WING	09/29/2020
		IDENTIFICATION NUMBER:  A. BUILDING:

## FRESH NEW START

4460 HUNTINGTON DRIVE

GASTONIA, NC 28056

	GASTO	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
V 110	Continued From page 20	V 110		
1	Associate Professional:			
	-Staff #8's certificate did not have the signature			
	of a person qualified to complete medication			
	administration training;			
	-Former Staff #12's certificate was dark			
	and illegible and had the certificate holder			
	name written on the side margin.			
	Refer to 10A NCAC 27G .0209 Medication			
	Requirements (V118) for specifics.			
	Interviews on 9/2/20-9/4/20 with management			
	members at the local recreational facility where			
	Former Client #1 and Former Client #A1			
	attended summer day camp revealed:			
	-Were informed Former Client #1 and			
	Former Client #A1 were from a foster home;			
	-"Was not made aware of their needs or challengesnot to the extent we would want			
	to be briefed;"			
	-"We just had very limited information about			
	the girls (Former Client #1 and Former Client			
	#A1); -Licensee #2/Executive Director was not			
	forthcoming about the needs of the girls when			
	registering the girls for camp.			
	Interviews on 8/10/20 - 9/25/20 with Licensee			
	#2/Executive Director failed to identify all			1
	current and former staff upon requests made			
	by the Division of Health Service Regulation.			
	Interview on 9/25/20 with Licensee #2/Executive			
	Director revealed:			
	-Nobody ever told them to train on individualized			
1	treatment plans or to meet the needs of the			
15	clients;			
	-Was not aware assessments needed to include			
	presenting problem, needs and strengths, provisional or admitting diagnosis, and pertinent			
	social, family, and medical history;			
	Service Regulation			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NOMBER.	A. BUILDING:		CON	MPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIP CODE			
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FRESHN	EW START		NIA, NC 28056				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)NI	1	
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V 110	Continued From pag	ne 21	V 110				
	-Was not aware treat be developed and im needs of the former of -Licensee #1/Director #1 signed Staff #8's in training certificate but provided the training: -Many Health Care Poor Criminal Background compliance because removed from the recommended there was laced although evidence was -Denied there was laced the Licensed Profess #2's although evidence was laced used to acknowled protected after an alled Staff #8; -Denied there was a content of the comments regard incident reporting; -No comments regard Alternatives to Restric Seclusion, Physical Round This deficiency is cross	tment strategies needed to applemented to address the clients; ar/Qualified Professional medication administration at a Registered Nurse; Personnel Registry and a checks were out of the original checks were cord and replaced when completed on each ack of proper staffing ratios as contradictory; as c	V 110				
	rule violation.	ppe (V293) for a Type A1					
	rule violation.						
	27G .0205 (A-B) Assessment/Treatmer	nt/Habilitation Plan	V 111				

Division of Health Service Regulation

STATE FORM 6899 S6LM11 If continuation sheet 22 of 132

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION G:	(X3) DATE COME	SURVEY	
		MHL036-336	B. WING		09/	29/2020	
NAME OF P	SUMMARY ST (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REATMENT/HABILIT PLAN (a) An assessment st client, according to get to the delivery of servinot be limited to: (1) the client's preser (2) the client's needs (3) a provisional or acceptablished diagnosis days of admission, exto a detoxification or of program shall have as upon admission; (4) a pertinent social, and (5) evaluations or assepsychiatric, substance	ASSESSMENT AND TATION OR SERVICE  and be completed for a poverning body policy, prior vices, and shall include, but an additional strengths; dmitting diagnosis with an additional destablished diagnosis family, and medical history; essments, such as abuse, medical, and iate to the client's needs.	A. BUILDING	G. TATE, ZIP CODE	og/s  og/s  og/s  ssments sive  ts.  ot will be  nt was ofessional review  -2 um will be tandard.  round onealth clinical centered og will be		
	establishment and imp treatment/habilitation or referred to as the "plan client's presenting prob This Rule is not met as Based on interview an	lementation of the or service plan, hereafter or strategies to address the olem shall be documented.		and APSM 45-2 requirements and clinic appropriateness.	al		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
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1780000000000			NIA, NC 28056			
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V 111	Continued From page	23	V 111			
	prior to the delivery of included presenting pr strengths, provisional of pertinent social, family affecting 5 of 5 audited Clients #1, #2, #3, #4,  Review on 8/28/20 of the Assessment Policy reversible.	services and assessments oblem, needs and or admitting diagnosis, and and medical history of former clients (Former and #5). The findings are:  the facility's undated realed:  assessed to appropriately				
	on each individual who for services and/or is retreatment, or evaluation appropriateness for additional treatment. Comprehensive Clinical be completed within 30 CCA's must be provided.	s of the family of the strevaluation is conducted to presents himself/herself eferred for assessment, on to determine streval mission and disposition t servicesThe al Assessment (CCA) will				
	considered for treatme potential clients shall b admission by the QP/L Professional/Licensed Counselor/Executive D can be done via phone or in person with the reparent/guardian. It will screening form. Screen the residential application guardian upon admission admitted to the Brighter initial admission assess This assessment will in date of screening, clien helpful to clients, input	ntScreening for e conducted prior to PC/ED (Qualified Professional birector). The screening , faxed over information ferring agency or be documented on the ning information is also on on completed by the on. When a client is r Dayz Group Home, an sment will be completed. clude the client's name, t triggers, interventions				

Division of Health Service Regulation

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED	
		MHL036-336	B. WING		09/	29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		20/2020	
FRESHN	EW START		JNTINGTON DRIV NIA, NC 28056	E			
	0.000.000		NIA, NC 20030				-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 111	Continued From page	24	V 111				
	CCA)"						
	Disorder and Attention Disorder; -11 years old; -Initial Assessment con Licensee #1/Director/0 #1 dated 12/26/19 did not include present strengths, provisional of pertinent social, family	ord revealed:  otive Mood Dysregulation Deficit Hyperactivity  mpleted by the Qualified Professional  ting problems, needs and or admitting diagnosis, and					
	Review on 8/11/20, 8/1 Former Client #2's reco -Admitted 7/10/20; -Discharged 8/7/20;	ord revealed:					
	and Attention Deficit Hy-9 years old;	Fraumatic Stress Disorder yperactivity Disorder; was available for review.					
	made available for reviewed requested via email on second email request v4:06pm as a reminder. sent to Licensee #1/Dir Professional #1 and Lic Director. On 8/17/20 at #2/Executive Director/Q Licensee #1/Director/Q	vas sent on 8/14/20 at The email requests were ector/Qualified censee #2/Executive 3:45pm, Licensee					

Division of Health Service Regulation

gone since 8/11/20) and would upload the

STATE FORM S6LM11 If continuation sheet 25 of 132

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		MHL036-336	B. WING		09/	29/2020
	PROVIDER OR SUPPLIER	4460 HU	ADDRESS, CITY, STAT JNTINGTON DRIV NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	Director was still out of family member's funer assessment was proven assessment assessm	ats. Licensee #2/Executive of town assisting with a ral arrangements. No ided.  12/20 and 8/18/20 of ord revealed: -  tion Deficit Hyperactivity stic Stress Disorder, isorder, Depression; -  appleted by the Licensee of of the diagnosis, and and medical history; -  esidential application were  12/20 and 8/18/20 of ord revealed:  sitional Defiant Disorder ma;  appleted by the Licensee of the diagnosis of the diag	V 111			

PRINTED: 10/15/2020 FORM APPROVED

Division of Health Service Regulation

1	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDED/SUPPLIED/OUA	OVOLAND TIPLE	20107511071011			_
		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	2000	TE SURVEY MPLETED	
				A. BOILDING.		-	W CE LED	
				B. WING				
			MHL036-336	D. WING		09	9/29/2020	
	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
	FRESH NE	EW START	4460 HI	UNTINGTON DRIV	E			
-			GASTO	NIA, NC 28056				
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
	V 111	Continued From page	e 26	V 111				
		Disruptive Mood Dys	rogulation Disorder					
		and Unspecified Trau						
		-10 years old;	,					
			th unclear signature dated					
		8/5/20 did not include						
			g diagnosis, and pertinent					
		social, family, and med	dical history.					
		Interview on 8/27/20	with Licensee					
		#1/Director/Qualified						
			e Director revealed: -The					
			ts is as follows: The facility					
		receives a CCA with a						
		Then, the facility com	T/2					
		with the strengths and	client and combines that					-
			application completed by				1	
			ample: DSS (Department					l
		of Social Services) wo						
		discharge to a higher						
			dum completed by the					
			I/Qualified Professional					
		lateral transition.	Addendum completed for a					
		atora transition.						
		Interview on 9/25/20 w	vith Licensee					
		#1/Director/Qualified F	Professional #1 and					
		Licensee #2/Executive						
			e Director was not aware					
		assessments needed						
		admitting diagnosis, and	trengths, provisional or					
		family, and medical his						
		-The facility had been of						
		assessments by combi						
			completed by the referring					
			ses to the following items:					
		- What are triggers for						
		-"What helps you calm						
		-"What happens when	you don't get your own					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	LE CONSTRUCTION G:		E SURVEY IPLETED
		MHL036-336	B. WING		09	29/2020
FRESH N	ROVIDER OR SUPPLIER  EW START	4460 HL GASTOI	INTINGTON DI			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ( CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETE DATE
V 112	assessment, and in pa legally responsible per- days of admission for of to receive services bey (d) The plan shall inclied. (1) client outcome(s) to be achieved by provision projected date of achied. (2) strategies; (3) staff responsible; (4) a schedule for revi- annually in consultation legally responsible persions. (5) basis for evaluation outcome achievement; (6) written consent or responsible party, or a presponsible party.	like to do?" why you are here?" ns?"  to complete a more assessment with all the future.  s referenced into 10A pe (V293) for a Type  t/Habilitation Plan  ASSESSMENT AND ATION OR SERVICE  developed based on the rtnership with the client or son or both, within 30 clients who are expected ond 30 days. ude: hat are anticipated to on of the service and a vement;  ew of the plan at least with the client or son or both; n or assessment of	V 112	V 112  To ensure compliance with standards an admission assessments and person-cer planning the agency's licensed mental h professional will review and approve all (admission) assessments and person-cer plans prior to implementation. The plans reviewed for compliance with DHSR stand APSM 45-2 requirements and clinical appropriateness.  In addition, the Qualified Professional witrained by a qualified instructor in Person Centered Planning elements. Documen will be kept on file.	ntered nealth clinical entered s will be ndards al	10/22/220

Division of Health Service Regulation

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	FE, ZIP CODE		
ERESH NI	EW START	4460 Ht	JNTINGTON DRIV	E		
TRESTIN	LIVOTARI	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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	failed to develop and address the needs of audited former clients #3, and #4). The finding Review on 8/11/20, 8 of Former Client #1's -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disruding Disorder and Attention Disorder; -11 years old; -Undated Residential assaultive, "extrem hit and kick things three to shower" -Initial Assessment co #1/Director/Qualified F12/26/19 revealed: " behaviors in the pastDischarge Summary of #1/Director/Qualified Prevealed difficulty with a personal space, strugg incidents of profanity, pverbal and physical agginates."	as evidenced by: nd record review, the facility implement strategies to the clients affecting 4 of 4 (Former Clients #1, #2, ngs are: /12/20 and 8/18/20 record revealed:  ptive Mood Dysregulation n Deficit Hyperactivity  Application revealed e aggressionrage will by thingsdoes not like mpleted by the Licensee Professional #1 dated .Possible sexualized	V 112			

Division	of Health Service Regu	lation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
ERESH N	EW START	4460 HU	JNTINGTON DRIV	E		
TRESITIO	LWSTART	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 OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 112	a summer day camp a intercourse in the past property destruction h physical aggression to concerns were reported behaviors of being una resulting in property defiance at least 4 to 5. Treatment plan update treatment strategies for sexualized comments, including property designers aggression. Furthermore	about having sexual t. Anger outbursts including ad increased as well as awards staff. Unspecified ad by camp staff. Client had able to control her impulses astruction, disrespect, and times per week; - a 8/6/20 did not include or hygiene issues, or anger outbursts truction and physical ore, there were no agarding placement at a	V 112			
	-Diagnosed with Post and Attention Deficit H -9 years old; -Treatment plan update of property destruction	e 7/11/20 revealed a history and desire for self-harm tegies to address property rm.  2/20 and 8/18/20 of ord revealed:				

sexualized behavior as she has gotten older and Division of Health Service Regulation

Disorder, Oppositional Defiant Disorder,

-Undated Residential Application revealed a history of running away and sexually inappropriate behaviors with " ...increased

Depression; -13 years old;

STATE FORM

6899

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	MHL036-336	B. WING	09/29/2020

### FRESH NEW START

## 4460 HUNTINGTON DRIVE 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 30	V 112		
	frequently talks about sex;" -Initial Assessment completed by the Licensee #1/Director/Qualified Professional dated 6/11/20 revealed Former Client #3 had a history of running away; -Discharge Summary completed by the Licensee #1/Director/Qualified Professional #1 dated 8/4/20 revealed Former Client #3 walked away from the facility premises several times and a "sexual assault allegation was filed against client and unsubstantiated;" -Comprehensive Clinical Assessment (CCA) addendum completed by the Licensed Professional/Qualified Professional #2 dated 8/17/20 revealed: "has no understanding of boundaries and she touches people inappropriately often rubbing on them and hugging without permission" -Treatment Plan dated 7/16/20 revealed a history of running away requiring reports to law enforcement. In June, 2020, she ran away and got into the car of a stranger and left for a "long period of time" requiring police intervention. She has had a recent increase in sexualized behaviors by frequently talking about sex and reporting she is having sex with peers. "Client is not able to maintain appropriate boundaries and will touch others and will 'smell' others. Client feels that this is a great personality traitClient storms out of the home when she is upset, yelling and using foul languageClient also demonstrates difficulty respecting appropriate boundaries and the personal space of staff and peers" Treatment plan did not include strategies to address running away and sexualized behaviors. Furthermore, there were no treatment strategies regarding placement at a summer day camp.  Review on 8/11/20, 8/12/20 and 8/18/20 of	VIIZ		
vision of Health	Service Regulation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL036-336		B. WING		09/29/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST.	ATE, ZIP CODE			
EDECLINI	EW START	4460 HUN	TINGTON DRI	VE			
FRESH N	EWSTART	GASTON	A, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 112	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; -Initial Assessment completed by the Licensee #2/Executive Director dated 4/23/20 revealed: " [Former Client #4] has destroyed property of other peers[Former Client #4] lies daily and will not take responsibility for her action. [Former Client #4] was caught kissing her room mate in previous placements[Former Client #4] creates stories and tell them to her mom, wanting her mom to file reports against others when she wants to move to a new placement" -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 inappropriate behaviors and "[Former Client #4] makes sexual comments to peers and displays sexual gestures[Former Client #4] is physically and verbally aggressive towards staff and peers at group home[Former Client #4] bullies younger peers in the group homeShe constantly lies on staff and		V 112				
	peers in her attempt to be sent home;" -Discharge Summary completed by Licensee #1/Director/Qualified Professional #1 dated 8/6/20						
	pushing a peer off the coallegation; -Treatment Plan update 8 #4 manifested several streaminues to be untruthful, a couch, and took anoth	aling peers' clothing, truth, physical assault by buch, and a sexual assault buch, and a sexual assault buch, and a sexual assault bries that are not factual and physically pushed a client off ner client's personal pictures up and threw them in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE  MHL036-336		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:			
		MHL036-336	B. WING		09/29/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
FDFGILM			JNTINGTON DRIV				
FRESH N	EW START	GASTO	NIA, NC 28056				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTION CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 112	Continued From page	e 32	V 112				
	, , , ,						
	plan did not include s						
	sexualized behaviors						
	allegations. Furtherm						
	a summer day camp.	regarding placement at					
	a summer day camp.	•					
	Interviews on 8/14/20	and 9/14/20 with					
	Former Client #1 reve						
	-The former clients at						
		summer day camp at a					
		ility 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 of		d in each other's rooms and					
	there was at least one incident of sexualized						
		ormer Client #2 and Former					
	Client #4.						
	Intervious on 0/2/20	0/4/20 with management					
	Interviews on 9/2/20-9/4/20 with management members at the local recreational facility where Former Client #1 and Former Client #A1 attended summer day camp revealed:  -Were informed Former Client #1 and Former Client #A1 were from a foster home;						
					1		
-"Was not made aware of the							
		e extent we would want					
	to be briefed;"	an manual success and success and the success of th					
-Cannot provide services effective		ces effectively if the staff					
	are not aware of the needs of the children; -						
After the incident between Former Client #1 and							
	Former Client #A1, the camp staff realized the						
		were greater than what			1		
	the camp staff could h						
	-Group home staff did	20 CO C C C C C C C C C C C C C C C C C C					
	campers during the da						
		ysically assaulted" Former					
		were in a violent fight;" -					
		ed information about the					
	girls (Former Client #1 and Former Client #A1);						

Division of Health Service Regulation

STATE FORM S6899 S6LM11 If continuation sheet 33 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL036-336	B. WING			09/29/2020
AME OF PROVIDER	OR SUPPLIER		ADDRESS CITY STAT	E 710 CODE	09/	29/2020
			ADDRESS, CITY, STAT JNTINGTON DRIVE			
RESH NEW STA	RT		NIA, NC 28056	-		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETE DATE
V 112 Conti	-Prior to being dismissed from the camp, they had previously been dismissed from another camp in a second neighboring town which fell under the same parent company; -Licensee #2/Executive Director was not forthcoming about the needs of the girls when registering the girls for camp; -The camp employed two coordinators: one had a degree in psychology and one had a degree in counseling. The coordinators assisted with coaching campers during behavioral concerns. The level of coaching was limited to verbal redirection during a disagreement and did not involve breaking up physical fights between campers.		V 112			
had p camp under -Licer fortho when -The o a degr in cou coach The le redired involve						
#2 rev -Forme there v	ealed: er Clients playe vas at least one ors between Fo	with Former Client  d in each other's rooms and e incident of sexualized former Client #2 and Former				
reveal -Attend Was tr Associ on diffe -Was r when t discov alterca to Forr #3 in tt -"I c girl sta and I fe	ed: ded a summer ansported to the ate Profession erent days; not allowed to se the director of the ered Former Clition with Former ener Client #A1 the throat; build not go back					

STATE FORM S6LM11 If continuation sheet 34 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336 B. WING		VING		09/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
EDESH NE	EW START	4460 H	JNTINGTON DRIVI	E		
LIVEOLIME	-W START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page 34		V 112			
V 112	-Former Client #4 e behaviors with peer -Former Client #3 or and went down their asked her questions She told him she wa said "f**k on!" Former the man and walked police were not invol Interview on 8/19/20 #3's Department of Worker revealed: -Had multiple conce -Former Client #3 habehaviors. She liked and was sexually act was a history of sexu history of inappropristaff allowed former with highly sexualize contemporary dance gestures; -Former Client #3 atte which the DSS Sociathe middle of July, 20 informed she could no verbal altercation with received documentati happened at the camp Interview on 8/25/20 #3's Adoption Recruitive -Former Client #3 atte because she was more to her behaviors.	ingaged in sexualized s; ince ran away from the facility road. She met a man who and asked how old she was. s 13-years-old and the man er Client #3 walked away from back to the facility. The ved in the incident.  I with Former Client Social with Former Client #3 walked away from back to the facility; da history of sexualized to talk about sex all the time ive with her boyfriend. There realized conversations but no attention to listen to songs and lyrics and dance a consisting of sexualized ended a cheerleading camp I Worker found out about in 20. Former Client #3 was not return to camp due to a nestaff at the camp; -Never on regarding what p.	V 112			
	revealed: -Former Client #3 wa	s kicked out of summer day				
	Service Regulation					

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PI

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	and the second s	(X3) DATE SURVEY COMPLETED			
MHL036-336			B. WING			09/29/2020		
	ROVIDER OR SUPPLIER	4460 H	ADDRESS, CITY, UNTINGTON D ONIA, NC 28056	RIVE	00/2		_	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETE DATE		
V 112	camp because of her behaviors; -Former Client #4 was kicked out of summer day camp for kissing boys; -Former Client #1 attended summer day camp; -Was in a peer's bedroom and engaged in sexualized behaviors with Former Client #2.  Interview on 8/12/20 with Former Client #4's DSS Social Worker revealed: -Many clients from the facility were sent to summer day camps.  Interview on 9/25/20 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director revealed: - Was not aware treatment strategies needed to be developed and implemented to address the needs of the clients; -Will ensure all treatment needs with corresponding strategies are included in the treatment plans in the future.  This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation.		V 112					
V 118	10A NCAC 27G .0209 REQUIREMENTS (c) Medication adminis (1)Prescription or non- only be administered to	stration: prescription drugs shall o a client on the written prized by law to prescribe e self-administered by prized in writing by the	V 118	V 118 To ensure compliance with this standard A staff that pass medication will have training by a registered nurse, pharmacist, or other legally qualified person prior to working. All that currently have medication administration training and pass medication will be require re-take the training.  To ensure compliance with standards arout this training the agency will contract with a Certified Forensic Healthcare Auditor to revand approve all personnel/training records to staff working and at the 3 month mark	l staff on ed to	0/22/220		

Division of Health Service Regulation

STATE FORM 6899 S6LM11 If continuation sheet 36 of 132

	IT OF DEFICIENCIES OF 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 P	ROVIDER OR SUPPLIER			TATE, ZIP CODE			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	A, NC 28056	DROVIDEDIO DI AN OF CORRECTION			
PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE	
	pharmacist or other leg privileged to prepare a (4) A Medication Adm all drugs administered kept current. Medication recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of the drug. (5) Client requests for acchecks shall be record.	icensed persons, or by ained by a registered nurse, gally qualified person and administer medications. inistration Record (MAR) of I to each client must be ons administered shall be after administration. The following:  Ind quantity of the drug; Iministering the drug; drug is administered; and if person administering  medication changes or ed and kept with the MAR pointment or consultation	V 118	V 118 Con't When the Certified Forensic Health Car contract expires a qualified agency staf assume the duties of monitoring compli this POC. The Certified Forensic Heal Auditor will train his replacement in star and audit practices.	f will ance witl th Care		
	failed to ensure staff re medication administrat registered nurse, phan qualified person affecti staff (Associate Profes	ion completed by a					
	findings are: Review on 9/9/20 of As record revealed: -Hire date 7/1/19; -No documentation of t	ssociate Professional's					

Division of Health Service Regulation

STATE FORM S6899 S6LM11 If continuation sheet 37 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		MHL036-336	B. WING		09/2	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE ZIP CODE		
			JNTINGTON DRIV			
FRESH N	EW START		NIA, NC 28056			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 37	V 118			
	administration.					
	Review on 9/8/20 and revealed:	d 9/9/20 of Staff #8's record				
	-Hire date of 6/5/20;					
		ration training certificate				
		ame of the employee is				
	not clear. The trainer's signature on the					
	certificate does not m					
		medication administration				
	training certificates for the agency. The trainer's signature is similar to the signature of Licensee #1/Director/Qualified Professional #1.					
	An additional copy of					1
		g certificate was requested				
		at 12:31pm. The email				
	request was sent to L #1/Director/Qualified					
	Licensee #2/Executive					
		need for an "additional				
		edication certificate (the				
		is difficult to read)." No				
	additional documenta	tion was provided.				
	Review on 9/9/20 of F	ormer Staff #12's				
	record revealed:	offici Stall #123				
	-Hire date of 6/4/20;					
	-Medication administra	ation certificate dated				
		Registered Nurse who				
		administration training				
	for the agency. The ce					
	hand written on the sid	er Staff #12's name was				
	nana willen on the Si	de of the certificate.				
	Interview on 9/21/20 w	vith Associate Professional				
	revealed:					
		e trainings he received but				
		been trained in medication				
	administration but could	not recall who provided				1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL036-336	B. WING	B. WING		/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
FRESH N	EW START		INTINGTON DRIV	Е		
			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 38	V 118			
	the training.					
	Employed as a Direct step in as House Man Received training in must but cannot recall who Recalled staff at the far medication administration administration administration because technician from another step in as House Man Received training administration because technician from another step in as House Man Received training administration because technician from another step in as House Man Received training administration because technician from another step in as House Man Received training administration because technician from another step in as House Man Received training at the step in as House Man Received training at the step in as House Man Received training at the step in as House Man Received training at the step in as House Man Received training at the step in as House Man Received training at the step in as House Man Received training at the step in a step i	nedication administration completed the training; - acility helped with stion training.  with Former Staff s at the facility and Sister as a Direct Care Worker; as in medication e she was a medication				
	at the facility; -Received minimal tra the job.	ining when she started				
	who provided the age medication administra The phone number fo was requested via em from Licensee #1/Dire	with the Registered Nurse ncy's previous training for attion was unsuccessful. In the Registered Nurse at all on 9/10/20 at 2:44pm actor/Qualified Professional xecutive Director. There he request.				
	signed Staff #8's media training certificate but a provided the training;	rofessional #1 and Director revealed: - Qualified Professional #1 cation administration				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Control Control Control Control	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL036-336			09/	29/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S NTINGTON DF	TATE, ZIP CODE			
FRESH N	EW START		IIA, NC 28056	(IVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE	
V 118	Continued From page	39	V 118				
		s referenced into 10A					
	Verification  G.S. §131E-256 HEAL REGISTRY (d2) Before hiring healt health care facility or se health care facility shall	ervice, every employer at a access the Health Care I shall note each incident of	V 131	V 131 To ensure compliance with standards are background checks to agency will conducted healthcare registry checks on all staff properties arting work. A historical record will be perpetuity of all checks.  To ensure compliance with standards are healthcare registry checks the agency we contract with a Certified Forensic Healthcard Auditor to review and approve all personnel/training records prior to staff wand at the 3 month mark.	oct ior to kept in ound ill care	10/22/220	
1	interview and record re ensure the Health Care (HCPR) was accessed documented prior to an affecting 7 of 10 audite #1/Director/Qualified Di #2/Executive Director, \$ #6, Staff #8, and Staff #	and the results offer of employment d current staff (Licensee irector #1, Licensee Staff #4, Staff #5, Staff #9) and 2 of 2 audited aff #11/Former Client #2's her Staff #12). The		When the Certified Forensic Health Care contract expires a qualified agency staff assume the duties of monitoring complia this POC. The Certified Forensic Health Auditor will train his replacement in standand audit practices.	will nce with n Care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL036-336	B. WING	09/29/2020
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE	
RESH NEW START	4460 H	UNTINGTON DRIVE	

# GASTONIA NC 28056

	GASTO	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 131	Continued From page 40  #1/Director/Qualified Professional #1's record revealed: -Hire date not recorded; -HCPR check completed on 1/30/19.  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 detect 12/20/10 and an the licensure	V 131		
	licensure dated 12/30/19 and on the license issued on 4/10/20.  Review on 9/8/20 of Initial Licensure Application with DHSR for Sister Facility A revealed: - Licensee #1/Director/Qualified Professional #1 was identified on the application for initial licensure dated 5/14/18 and on the license issued on 6/13/18.  Review on 9/8/20 and 9/9/20 of Licensee #2/Executive Director's record revealed: -Hire date of 8/1/18;			
	-HCPR check completed 1/26/20.  Review on 9/9/20 of Staff #4's record revealed: -Hire date of 7/1/20; -HCPR check completed 6/23/20; -Agency training completed between 6/16/20 and 6/20/20.			
	Review on 9/9/20 with Staff #5 revealed: -Hire date of 6/24/20; -HCPR completed 6/23/20; -Agency training completed between 6/17/20 and 6/24/20.			
7	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			

Division of Health Service Regulation

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
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		MHL036-336	C. WIIIC		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT			
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Wheels in Section	1		NIA, NC 28056			
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V 131	Continued From page	41	V 131			
	staff records were ser #1/Director/Qualified I Licensee #2/Executive 9:53am for the record again on 9/8/20 at 1:3 be sent via secured at Review on 9/8/20 and revealed:	nt to Licensee Professional #1 and e Director on 9/4/20 at s to be sent via fax and 4pm for the records to				
	-Hire date of 6/5/20;					
	-HCPR check complet -Agency training comp 6/3/20.	ed 6/3/20; elleted between 5/20/20 and				
	Review on 9/8/20 and revealed: -Hire date of 12/27/19; -No HCPR check comp					
	Client #2's Grandmoth -No hire date recorded -HCPR check complete	,				
	revealed: -Hire date of 6/4/20; -HCPR check complete	ormer Staff #12's record ed 6/3/20; leted between 5/21/20 and				
	unsuccessful. A phone	call back. No call was ever				
	Interview on 9/11/20 wi Could not identify the s started, but believed it v	pecific date employment				

Division	of Health Service Regu	ulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/2	29/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
ERESH NE	EW START	4460 HI	JNTINGTON DRIVI	E		
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V 131	Continued From pag	ge 42	V 131			
	Interview on 9/11/20 -Start date was 5/5/20	with Staff #8 revealed: 0.				
	Interview on 9/2/20 v revealed: -Start date was 5/22/	with Former Staff #12 /20.				
	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv					

-The hire date in the record reflected when they were officially hired after training was completed; -Many HCPR checks were out of compliance because the original HCPR checks were removed from the record and replaced when annual HCPR checks were completed on each employee;

were selected and received training for which they were financially compensated through a

-Will complete HCPR checks prior to training new staff;

-Will keep original HCPR checks in the employee record in the future.

This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation.

V 132 G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection

> G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to

Division of Health Service Regulation

bonus:

V 132

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		The state of the s	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	33577	(X5) COMPLETE DATE
	(which includes: a. Neglect or abuse of facility or a person to widefined by G.S. 131E-2 b. Misappropriation of in a health care facility, (b) of this section includes as defined hospice services as defined hospice services as debeing provided. c. Misappropriation healthcare facility. d. Diversion of drugs facility or to a patient of e. Fraud against a heal a patient or client for will providing services). Facilities must have acts are investigated a effort to protect resider investigation is in proginvestigations must be	vision (a)(1) of this section.  of a resident in a healthcare thom home care services as 136 or hospice services as 201 are being provided.  of the property of a resident as defined in subsection ding places where home ad by G.S. 131E-136 or fined by G.S. 131E-201 are of the property of a sellonging to a health care for client.  ealth care facility or against from the employee is sevidence that all alleged and must make every the form harm while the ress. The results of all reported to the working days of the initial	V 132	V 132  The agency ensure that DHSI notified of all allegations again health care personnel, includi injuries of unknown source, wappear to be related to any active below:  a. Neglect or abuse of a resident.  b. Misappropriation of the property of a resident c. Misappropriation of the property of a healthcare facility d. Diversion of drugs belo to a the agency or to a client.  e. Fraud against a health facility or against a client for with the employee is providing sent.  The agency will investigate all allegation an maintain evident that all alleged acts are investigated and must make every effort to protect clients from harm while investigation is in progress. Specifically, the staff in questic be suspended until la determinis made.	y. nging care hom vices. such ce gated e the	10/22/220
	This Rule is not met as Based on interview and	evidenced by: d record review, the facility				

Division of Health Service Regulation

STATE FORM S6890 S6LM11 If continuation sheet 44 of 132

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP  A. BUILDING	LE CONSTRUCTION 3:	(X3) DATE COMF	SURVEY
		MHL036-336	B. WING		09/2	9/2020
	ROVIDER OR SUPPLIER	4460 HU	ADDRESS, CITY, S JNTINGTON DF NIA, NC 28056			
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V 132	Department and faile harm during the investable audited current staff ( Review on 8/11/20, 8 of Former Client #3's Admitted 6/12/20; -Discharged 8/4/20; -Discharged 8/4/20; -Diagnosed with Atten Disorder, Post Trauma Oppositional Defiant Dyears old.  Review on 9/8/20 and revealed: -Hire date of 6/5/20.  Review on 8/12/20 and Incident Reports dated No incident reports regabuse involving Staff #3.  Interview on 8/10/20 w#1/Director/Qualified PThe local Department was in process of investables involving Staff #3; -Did not believe there the allegation.  Interview on 8/14/20 w#1 revealed:	egations of abuse to the d to protect clients from stigation affecting 1 of 10 Staff #8). The findings are:  8/12/20 and 8/18/20 record revealed: -  tion Deficit Hyperactivity atic Stress Disorder, Disorder, Depression; -13  d 9/9/20 of Staff #8's record  d 8/13/20 of the facility's 17/1/20 - 8/7/20 revealed: -  garding an allegation of 18 choking Former Client  with Licensee rofessional #1 revealed: -  of Social Services (DSS) stigating an allegation of 8 choking Former Client  was any truth to  with Former Client	V 132	V 132 Con't  The agency will report all sallegations to the DHSR Herotare Personnel Registry whour of the allegation and values and subsequently report the resinvestigations within five word days of the initial notification DHSR.	ealth ithin 24 vill sults of all orking	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETED		
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	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE	
	-"One day [Staff #8 hands on my throat be was in the van at [Sist remember who was d Interview on 8/19/20 v Social Worker revealed -Upon arrival at the facility staff member, and otherwise was in the presence member who had alled Interview on 8/13/Client #4 revealed hands around Forthroat and tried to a The incident occurred way of Sisted #8 and Former Client #3 later debecause she liked Interview on 9/11/20 w Denied putting her hard Client #3's neck.  Interview on 9/25/20 w #1/Director/Qualified Fuccessed #2/Executive -No comment.	got really mad and put her ut did not really choke me. I er Facility A]Cannot riving the van"  with Former Client #3's DSS ed: cicility to pick up Former former Client #3 was with Staff #8, a second her clients; ed that Former Client eof the same staff gedly choked her.  20 with Former di: -Staff #8 put her mer Client #3's choke her; urred on the r Facility A; -Staff ient #3 were ther; -Former nied the incident di Staff #8.  with Staff #8 revealed: -India around Former  with Licensee Professional #1 and a Director revealed: -India sereferenced into 10A	V 132				
(	(X4) ID REFIX TAG V 132	V 132 Continued From page -"One day [Staff #8 hands on my throat be was in the van at [Sist remember who was d  Interview on 8/19/20 v Social Worker reveals -Upon arrival at the fa Client #3 on 8/4/20, F away from the facility staff member, and oth -Was deeply concerne #3 was in the presence member who had alle  Interview on 8/13/Client #4 revealed hands around For throat and tried to The incident occ driveway of Siste #8 and Former Cl cursing at each o Client #3 later de because she liked Interview on 9/11/20 w Denied putting her har Client #3's neck.  Interview on 9/25/20 w #1/Director/Qualified F Licensee #2/Executive -No comment.  This deficiency is cross	RESH NEW START  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 132  Continued From page 45  -"One day [Staff #8] got really mad and put her hands on my throat but did not really choke me. I was in the van at [Sister Facility A]Cannot remember who was driving the van"  Interview on 8/19/20 with Former Client #3's DSS Social Worker revealed:  -Upon arrival at the facility to pick up Former Client #3 on 8/4/20, Former Client #3 was away from the facility with Staff #8, a second staff member, and other clients;  -Was deeply concerned that Former Client #3 was in the presence of the same staff member who had allegedly choked her.  Interview on 8/13/20 with Former Client #4 revealed: -Staff #8 put her hands around Former Client #3's throat and tried to choke her;  -The incident occurred on the driveway of Sister Facility A; -Staff #8 and Former Client #3 were cursing at each other; -Former Client #3 later denied the incident because she liked Staff #8.  Interview on 9/11/20 with Staff #8 revealed: -Denied putting her hands around Former Client #3's neck.  Interview on 9/25/20 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director revealed: -No comment.  This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type	AME OF PROVIDER OR SUPPLIER  RESH NEW START  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 132  Continued From page 45  -"One day [Staff #8] got really mad and put her hands on my throat but did not really choke me. I was in the van at [Sister Facility A]Cannot remember who was driving the van"  Interview on 8/19/20 with Former Client #3's DSS Social Worker revealed: -Upon arrival at the facility to pick up Former Client #3 on 8/4/20, Former Client #3 was away from the facility with Staff #8, a second staff member, and other clients; -Was deeply concerned that Former Client #3 was in the presence of the same staff member who had allegedly choked her.  Interview on 8/13/20 with Former Client #3's throat and tried to choke her; -The incident occurred on the driveway of Sister Facility A; -Staff #8 and Former Client #3 were cursing at each other; -Former Client #3 later denied the incident because she liked Staff #8.  Interview on 9/11/20 with Staff #8 revealed: -Denied putting her hands around Former Client #3's neck.  Interview on 9/25/20 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director revealed: -No comment.  This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type	AME OF PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEPICIENCES  SUMMARY STATEMENT OF DEPICIENCIES  SUMMARY STATEMENT OF DEPICIENCIES  FROUDERS PLAN OF CORRECTION  FRESH NEW START  SUMMARY STATEMENT OF DEPICIENCIES  FROUDERS PLAN OF CORRECTION  FRESH NEW START  SUMMARY STATEMENT OF DEPICIENCIES  FROUDERS PLAN OF CORRECTION  FRESH NEW START  SUMMARY STATEMENT OF DEPICIENCIES  FROUDERS PLAN OF CORRECTION  FRESH NEW START  FROUDERS PLAN OF CORRECTION  FROM THE ACCHORDANT  FROUDERS PLAN OF CORRECTION  FROM THE ACCHORDANT  FROM TAKE TO THE APPROPER  FROM THE ACCHORDANT  FRO	AME OF PROMOTER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4460 HUNTINGTON DRIVE  GASTONIA, NO 28056  XAJID  REFIX  ICACH DEPRICENCY MUST SE PRECEDED BY PULL  REGULATORY OR LECIDENTIFYING INFORMATION)  V 132  Continued From page 45  -"Che day [Staff #8] got really mad and put her hands on my throat but did not really choke me. I was in the van at [Sister Facility A]Cannot remember who was driving the van"  Interview on 8/19/20 with Former Client #3's DSS  Social Worker revealed: -Upon arrival at the facility to pick up Former Client #3 on 8/4/20, Former Client #3 was alway from the facility with Staff #8, a second staff member, and other clients; -Was deeply concerned that Former Client #3 was in the presence of the same staff member who had allegedly choked her.  Interview on 8/13/20 with Former Client #4 revealed: -Staff #8 put her hands around Former Client #3's throat and tried to choke her; -The incident occurred on the driveway of Sister Facility A; -Staff #8 and Former Client #3's throat and tried to choke her; -The incident occurred on the driveway of Sister Facility A; -Staff #8 and Former Client #3 avere cursing at each other; -Former Client #3 later denied the incident because she liked Staff #8.  Interview on 9/11/20 with Staff #8 revealed: -Denied putting her hands around Former Client #3 seck.  Interview on 9/25/20 with Licensee #1/Cirector/Qualified Professional #1 and Licensee #2/Exocutive Director revealed: -No comment.  This deficiency is cross referenced into 1DA NCAC 27G .1701 Scope (V283) for a Type	AME OF PROMOTER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4460 HUNTINGTON DRIVE  GASTONIA, NC 28056  SUMMARY STATEMENT OF DEPICIENCIES  [PROHIDERGENCYMUST BE PRECEDED BY FULL  [PROHIDERGENCYMUST BE BERGENDED BY FULL  [PROHIDERGENCYMUST BERGENDED BY FULL  [PROHIDERGENCYMUST BE BERGENDED BY FULL  [PROHIDERGENCYMUST BERGENCED BY FULL  [PROHIDERGENCYMUST BERGENCED BY FULL  [PROHIDERGENCYMUST BERGENCED BY FULL  [PROHIDERGENCED BY FULL  [PROHIDER BY FUL

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ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COMF	PLETED
		MHL036-336	B. WING		09/2	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE ZIP CODE	-	
			JNTINGTON DE			
FRESH N	EW START		NIA, NC 28056			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
V 133	Continued From page	2 46	V 133	V 133		10/22/220
V 133	G.S. \$122C-80 Criminal G.S. \$122C-80 CRIMI RECORD CHECK RE APPLICANTS FOR EI (a) Definition As use "provider" applies to a program and any providevelopmental disabil services that is licensal Chapter. (b) Requirement An provider licensed under applicant to fill a position applicant to have an or conditioned on consent criminal history record the applicant has been less than five years, the is conditioned on consection criminal history record antional criminal history a check of the applicant applicant has been a re years or more, then the consent to a State crim the applicant. A provide applicant who refuses the history record check reference Except as otherwise provided submit a request to the	INAL HISTORY EQUIRED FOR CERTAIN MPLOYMENT. ed in this section, the term in area authority/county vider of mental health, ity, and substance abuse able under Article 2 of this offer of employment by a er this Chapter to an on that does not require the ocupational license is t to a State and national check of the applicant. If a resident of this State for en the offer of employment ent to a State and national check of the applicant. The y record check shall include this fingerprints. If the estident of this State for five to offer is conditioned on inal history record check of er shall not employ an o consent to a criminal quired by this section. by of making the elloyment, a provider shall	V 133 V 133	To ensure compliance with standards a background checks to agency will cond criminal records checks in accordance §122C-80 on all staff prior to starting whistorical record will be kept in perpetuit checks.  To ensure compliance with standards at criminal record checks the agency will with a Certified Forensic Healthcare Aureview and approve all personnel/trainin records prior to staff working and at the mark.  When the Certified Forensic Health Care contract expires a qualified agency staff assume the duties of monitoring compliathis POC. The Certified Forensic Health Auditor will train his replacement in standand audit practices.	with G.S. ork. A by of all round contract ditor to ng 3 month e Auditor will ance with h Care	10/22/220
5	State criminal history re	rivate entity to conduct a cord check required by				
	this section. Notwithstar Department of Justice s	nding G.S. 114-19.10, the shall				

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	MHL036-336	B. WING	09/29/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### FRESH NEW START

### 4460 HUNTINGTON DRIVE 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.  (c) Action If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:	V 133		

Division of Health Service Regulation

STATE FORM

AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL036-336	B. WING		09/	29/2020
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIP CODE		20,2020
EDECLINEW OTABE		INTINGTON DRIV			
FRESH NEW START	GASTO	NIA, NC 28056			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
<ul> <li>(2) The date of the of</li> <li>(3) The age of the period of the conviction.</li> <li>(4) The circumstance commission of the crime</li> <li>(5) The nexus between of the person and the job to be filled.</li> <li>(6) The prison, jail, properson since the date the</li> </ul>	riousness of the crime. erson at the time  es surrounding the e, if known. een the criminal conduct of duties of the position  robation, parole, remet records of the errime was committed. It commission by the nse. It relevant offense alone loyment; however, the isidered by the provider. Is an applicant after rant factors, then the formation contained in It check that is relevant er may not provide a copy ord check to the  provider and an officer er that, in good faith, eshall be immune from  there to employ an information provided in check of the individual. Inployee's history of imployee's criminal quested and received ection.  used in this section, a county, state, or conviction or pending	V 133			

STATEMENT OF DEFICIENCIES AND PLAN OF 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 PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### FRESH NEW START

## 4460 HUNTINGTON DRIVE

	GASTO	NIA, NC 28056		
X4) ID SUMMARY STATEMENT OF REFIX (EACH DEFICIENCY MUST BE IT AG REGULATORY OR LSC IDENTIFICATION.	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
REFIX (EACH DEFICIENCY MUST BE	vidual's fitness to by and well-being alth, ubstance abuse the criminal following Articles tatutes: Article 5, setary Substitutes; ive and lomicide; Article 8, grand Abduction; amage by Use of or Material; Housebreakings; nings; Article 16, rticle 18, grand Property or to Use of Credit 19B, Financial ticle 20, Frauds; offenses Against ticle 26A, Adult titution; Article 31, cle 35, Offenses e 36A, Riots and ction of Minors; ally; Article 59, o, Computerso include colation of the ances Act, neral Statutes, that as sale to G.S. 18B-302 or	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE

6899

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Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		MHL036-336	B. WING		09/:	29/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
FRESHN	EW START		NTINGTON DRI	VE		
			NIA, NC 28056	T		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	(f) Penalty for Furnish applicant for employmes supplies, or otherwise an employment applicatoriminal history record shall be guilty of a Clast (g) Conditional Emplotemploy an applicant or obtaining the results or record check regarding the following requirem (1) The provider shall prior to obtaining the acriminal history record subsection (b) of this stringerprint cards as required (2) The provider shall criminal history record business days after the conditional employmer 2001-155, s. 1; 2004-12005-4, ss. 1, 2, 3, 4, 5.  This Rule is not met as Based on interview and failed to ensure criminal completed within five be conditional offer of empaudited current staff (Li #1/Director/Qualified Pringles) and 2 of 2 audited form	ing False Information Any ent who willfully furnishes, gives false information on ation that is the basis for a check under this section is A1 misdemeanor.  Syment A provider may conditionally prior to fa criminal history givents are met:  The applicant if both of ents are met.  The applicant if both of ents are met.	V 133			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
FRESH N	EW START	4460 HU	JNTINGTON DRIV	/E		
- INEOITIN	LIV OTAIL!	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 133	Continued From page Review on 9/8/20 and #1/Director/Qualified record revealed: -Hire date not record -Criminal background on 1/30/19.	d 9/9/20 of Licensee Professional #1's ed; I check completed	V 133			
	with the Division of He (DHSR) for the facility -Licensee #1/Director #1 was identified on tilicensure dated 12/30 issued on 4/10/20.	/Qualified Professional he application for initial /19 and on the license				
	with DHSR for Sister	Qualified Professional #1 application for initial				
	Review on 9/8/20 and #2/Executive Director -Hire date of 8/1/18; -No criminal backgrou	s record revealed:				
	#6's records was unsulvere made available for the staff records were #1/Director/Qualified For Licensee #2/Executive 9:53am for the records	Professional #1 and e Director on 9/4/20 at s to be sent via fax and 4pm for the records to be encrypted				
	record revealed:	orozzo di Otali #03				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING				
					09/	29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA JNTINGTON DRIV				
FRESHN	EW START		NIA, NC 28056	,,,			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE	
V 133	Continued From page	52	V 133				
	-Hire date of 6/5/20;						
		check completed 6/3/20; -					
	Agency training comp 6/3/20.	leted 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						
		check completed 12/20/19;					
	12/20/19.	pleted between 12/3/19 and					
	Review on 9/8/20 of F	ormer Staff #11/Former					
	Client #2's Grandmoth						
	-No hire date recorded	l; check completed 12/21/19;					
		eleted in 2018 and 2019.					
	Review on 9/9/20 of Fe	ormer Staff #12's					
	record revealed: -Hire date of 6/4/20;						
	-Criminal background	completed 6/3/20			1		
		leted between 5/21/20 and					
	6/15/20.						
		ith Licensee #2/Executive					
	Director revealed:	Lancour de Lancour de la constant					
	<ul> <li>-Had a pending child a neighboring county;</li> </ul>	buse charge in a					
	-The charge involved h	er son:					
	-It was a misunderstan						
	cleared and the charge						
	-The case will be heard	d in court on 12/4/20.					
	Interview on 9/11/20 wi -Start date was 5/5/20.	th Staff #8 revealed:					
	Interview on 9/2/20 with	n Former Staff #12					
1	revealed: -Start date was 5/22/20	);					

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	TIPLE CONSTRUCTION		E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	5:	COMPLETED	
		MHL036-336	B. WING		09	/29/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EDECLINE	TWOTART		ITINGTON DE			
FRESH NE	WSTART	GASTONI	IA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 133	Continued From pag	e 53	V 133			
	-After having worked approximately 1 months		V 133			
	were selected and re they were financially bonus; -The hire date in the re were officially hired aff-Many criminal backgr compliance because t were removed from the when annual criminal completed on each en-Will complete criminal prior to training news -Will keep original crimin the employee reconsumment of the employee reconsumment	Professional #1 and we Director revealed: -Staff ceived training for which compensated through a  ecord reflected when they ter training was completed; cound checks were out of the original HCPR checks the record and replaced background checks were enployee; tal background checks totaff; minal background checks and in the future.  The series referenced into 10A tope (V293) for a Type  If Tx. Child/Adol - Scope the SCOPE the staff secure facility for the sis one that is a free- cility that provides the securic treatment and the system of care approach. It ty residence of an	V 293	Cross reference to response to V108, 109,110,111,112,118,131,132, 133, 296,297,364,366,367,536,& 537		10/22/220

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
FRESHN	EW START	4460 HU	NTINGTON DRIV	√E		
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	shall be continuous as of this Section.  (c) The population ser adolescents who have mental illness, emotion substance-related disc co-occurring disorders disabilities. These chilk not meet criteria for inp (d) The children or addrequire the following:  (1) removal from community-based resi facilitate treatment; an (2) treatment in (e) Services shall be did (1) include indiviand structure of daily lift (2) minimize the related to functional de (3) ensure safet control behaviors incluing management with or with acquisition of adaptive communication, social	ved shall be children or a primary diagnosis of hal disturbance or orders; and may also have including developmental dren or adolescents shall patient psychiatric services. Diescents served shall on home to a dential setting in order to do a staff secure setting. esigned to: idualized supervision iving; occurrence of behaviors ficits; y and deescalate out of ding frequent crisis orithout physical restraint; ild or adolescent in the functioning in self-control, and recreational skills; and child or adolescent in ed to step-down to a not setting. In ment staff secure with other individuals	V 293			

Division of Health Service Regulation

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
		MHL036-336	B. WING		09.	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
FRESH N	EW START	4460 HU	UNTINGTON DRIV	E		
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	This Rule is not met as Based on interview, re observation, the facility individualized supervisiving, minimize the occretated to functional dedescalate out of contracquisition of adaptive skills needed to step-d treatment setting affect clients (Former Clients The findings are:  CROSS REFERENCE Personnel Requirement Based on interview, reconstruction, reconstruct	s evidenced by: cord review, and y failed to provide sion and structure of daily currence of behaviors eficits, ensure safety and rol behaviors, assist in the functioning and gaining the own to a less intensive ting 5 of 5 audited former at 1, #2, #3, #4, and #5).  10A NCAC 27G .0202 hts (V108) cord review, and	V 293	DEFICIENCY)		
	served affecting 8 of 10 (Licensee #1/Director/C Licensee #2/Executive Professional, Staff #4, #8, and Staff #9) and 2 (Former Staff #11/ Formand Former Staff #1/ Formand Former Staff #1/ Formand Former Staff #1/ Formand Forma	tet the needs of the clients of audited staff members Qualified Professional #1, Director, Associate Staff #5, Staff #6, Staff of 2 audited former staff mer Client #2's ner Staff #12).  10A NCAC 27G .0203 fied Professionals and s (V109) ord review, and ded current qualified ensed professional #2) and 1 of 1 te professional (Associate				

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	or trouting of the or togu	Tation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	Andrew St. Committee	E SURVEY MPLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
FRESH N	EW START		JNTINGTON DRIVI	<u> </u>		
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	56	V 293			
	skills, and abilities requserved.  CROSS REFERENCE0204 Competencies a Paraprofessionals (V1 Based on interview an audited current parapr #2/Executive Director) knowledge, skills, and population served.  CROSS REFERENCE	eired by the population  2: 10A NCAC 27G  2: 10A NCAC 27G				
	or Service Plan (V111) Based on interview and failed to ensure assess prior to the delivery of sincluded presenting pro	d record review, the facility ments were completed services and assessments oblem, needs and or admitting diagnosis, and and medical history former clients (Former				
	or Service Plan (V112) Based on interview and failed to develop and im address the needs of the	Treatment/Habilitation record review, the facility				
	Medication Requirement Based on interview and failed to ensure staff rea medication administration registered nurse, pharm	record review, the facility ceived training in on completed by a				

		1				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE		
FRESH NI	EW START		INTINGTON DRIV	/E		
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	e 57	V 293			
V 293	staff (Associate Profe of 2 audited former staff (Associate Profe of 2 audited former staff (Associate Professor Reference 256 Health Care Personnel Registry (Hearth the results documente employment affecting staff (Licensee #1/Direction Licensee #2/Executive #5, Staff #6, Staff #8, audited former staff (Find Client #2's Grandmoth CROSS REFERENCE 256 Health Care Person Based on interview ar facility failed to report the Department and facility failed to report staff (Find Professor Reference Person Research Professor Reference Person Research Professor Person Reference Person R	essional and Staff #8) and 1 taff (Former Staff #12).  E: General Statute 131E- connel Registry (V131) and record review, the e the Health Care alcPR) was accessed and ed prior to an offer of 7 of 10 audited current ector/Qualified Director #1, e Director, Staff #4, Staff and Staff #9) and 2 of 2 Former Staff #11/Former her and Former Staff #12).  E: General Statute 131E- connel Registry (V132) and record review, the all allegations of abuse to ealled to protect clients from tigation affecting 1 of 10	V 293			
	80 Criminal History Re Based on interview an facility failed to ensure checks were complete days of making a cond employment affecting staff (Licensee #1/Dire Professional #1, Licen Staff #6, Staff #8, Staff former staff (Former S Grandmother and Form	d record review, the criminal background did within five business ditional offer of 5 of 10 audited current ector/Qualified see #2/Executive Director, f #9) and 2 of 2 audited taff #11/Former Client #2's mer Staff #12).				
		: 10A NCAC 27G .1704 uirements (V296) Based view, and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/:	29/2020
	ROVIDER OR SUPPLIER	4460 HU	DDRESS, CITY, STANTINGTON DRIN			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	care staff when one, to were present and failed clients when they were affecting 5 of 5 former #2, #3, #4, and #5).  CROSS REFERENCE Requirements of Lice (V297) Based on integration, the face-to-face clinical chours per week with CROSS REFERENCE Additional Rights in a stage on interview and failed to ensure common with parents or guardicindividual having legal by the facility affecting clients (Former Clients CROSS REFERENCE Incident Response Read and B Providers (V3 Based on interview and failed to ensure all incident in their policy of CROSS REFERENCE Incident Reporting Read and B Providers (V3 Based on interview and failed to report the LME (local manage for the catchment aread facility failed to report the LME (local manage for the catchment aread facility failed to report the catchment ar	ry failed to ensure two direct wo, three, or four clients ed to ensure supervision of e away from the facility clients (Former Clients #1,  EE: 10A NCAC 27G .1705 ensed Professionals erview, record review, facility failed to ensure consultation at least four a licensed professional.  E: General Statute 122C-62 24-Hour Facility (V364) dd record review, the facility unication and consultation en or the agency or custody without restriction 5 of 5 audited former s #1, #2, #3, #4, and #5).  E: 10A NCAC 27G .0603 equirements for Category 366) dd record review, the facility dents were reported as and procedure.  E: 10A NCAC 27G .0604 quirements for Category 367) and record review, the all Level III incidents to be ment entity) responsible	V 293			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
FRESH NE	W START		NTINGTON DRIV IIA, NC 28056	E		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETE DATE
	CROSS REFERENCE Least Restrictive Alter Based on interview and facility failed to ensure affecting 5 of 5 audited Clients #1, #2, #3, #4,  CROSS REFERENCE .0107 Training on Alte Interventions (V536) Based on interview and facility failed to ensure alternatives to restrictive 1 of 10 audited staff mand CROSS REFERENCE Training in Seclusion, Isolation Time-Out (V536) Based on interview and failed to ensure staff we physical restraint and is 1 of 10 audited staff mand CROSS REFERENCE .0104 Storage and Pro Possessions (V541) Based on interview and failed to protect clients' affecting 3 of 5 audited Clients #1, #3, and #4).  Finding #1 Interview on 8/14/20 wi revealed: -Former clients were al other's rooms until "[ raping [Former Clients #2 and on;	E: 10A NCAC 27E .0101 native (V513) Ind record review, the e a respectful environment of former clients (Former and #5).  E: 10A NCAC 27E rnatives to Restrictive d record review, the e staff were trained in eve interventions affecting embers (Staff #6).  E: 10A NCAC 27E .0108 Physical Restraint, and Barry	V 293			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		0.	9/29/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
FRESH	IEW START	4460 HU	NTINGTON DR	RIVE			
		GASTON	IIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE	
	air and threw Former Clients #2 an and did not touch eac while Former Client #1 Former Client #1 Former Client #1 Former Client #1 left threstaff #6 was in the living revealed:  -Former Clients #1, #2 playing dolls when For into the room;  -Former Client #4 begger Former Client #4 begger Former Client #4 was and Former Client #4 the would flip her over;  -Former Client #4 "di had no business doingshe was trying to huid play begger former Client #4 wold flip her over;  -Former Client #3 told but Former Client #3 told but Former Client #4 were in the living room.  Interview on 9/3/20 with revealed:  -On 8/3/20, Former Clients #2 in a sexual position Both Former Clients #clothed; -Former Client #3 told in the sexual position.	Former Client #2 up in the Client #2 onto the bed; at #4 had their clothes on h other's "private parts" was in the room; - ne room to tell Staff #6; ving room with another staff.  With Former Client  2, and #3 were in the room rmer Client #4 snuck  an "acting like a boy;" to Former Client #2 over  behind Former Client #2 over  behind Former Client #2 she  id inappropriate stuff sheshe grabbed my leg mp me;"  under clothes; Former Client #4 to stop yould not stop; in the house but the staff in.  th Former Client #3  sent #4 put Former Client ; 2 and #4 were fully  Former Client #4 to stop; - aff were in the living room usiness"	V 293				
		in i diffici dicin <del>114</del>					

Difficion of Fredicti Collino	o riogolation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUM	, -,	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	MHL036-336	B. WING		09/29/2020
NAME OF PROVIDER OR SUPPL	IER	STREET ADDRESS, CITY, S	TATE, ZIP CODE	
EDECLINEW CTART		4460 HUNTINGTON DE		
FRESH NEW START		GASTONIA, NC 28056		
PREFIX (EACH DI	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY I ORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
allowed out of a would play in e were in the livir -On 8/3/20, the a bedroom; -Staff #6 was ir was present but second staff was been Staff #8. It -Former Client would help her Former Client # the bed and state Former Client # sexual.  Review on 9/28 dated 9/29/20 state #1/Director/Quate which was an accomply with all a consumers in its care staff return  V108: Fresh Necomply with all a conviction.  b. A file shall the	s #1, #2, #3, and #4 were not heir bedrooms until 10am so ach other's rooms while staffing room; former clients were playing on the living room. A second state the was not certain who theres but believes it may have sooth staff were sleeping; #4 told Former Client #2 shered a headstand on the bed; -4 pushed Former Client #2 or ted a "humping action; 4 did not mean for it to seem will be action will the facility take to yof the consumers in your cases how Start will the said, Fresh New Start will the said of the facility.	they  dolls  aff e  ver  tion  ed:  re?  t ake  ect  7G  nal		

Division of Health Service Regulation

6899

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Division of Health Service Regulation

		TOTAL TOTAL				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL036-336	B. WING		09/	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST.			
FRESH N	EW START		JNTINGTON DRI	VE		
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page		V 293			
	<ul> <li>c. qualifications for to verification of licensur</li> </ul>					
	certification. d. Employee training	_				
	provided and, at a mi	nimum, shall consist of				
	the following: (1) general organizat					
(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and						
(3) 10A NCAC 26B; (4) training to meet the mh/dd/sa (mental						
	health/developmental abuse) needs of the d	disability/substance				
	treatment/habilitation	plan; and				
	<ul><li>(5) training in infectio bloodborne pathogen</li></ul>					
	Specifically, the agenc	y will require all new and				
	1 To	new background checks ency-based training in Item				
	D (1-4) above. All pers to ensure compliance	sonnel files will be audited with this standard				
	V109: Fresh New Sta requirements of 10A I					
	including ensuring the Qualified Professiona					
	Qualified Professiona	I will receive training by a				
	qualified trainer within  1. technical knowled	The Charles of the Control of the Co				
	2. cultural awareness					
	<ol> <li>analytical skills;</li> <li>decision-making;</li> </ol>					
	<ul><li>5. interpersonal skills</li><li>6. communication sk</li></ul>					
	7. clinical skills.	ino, and				
	V110: Fresh New Star					
		competency of the Para				
	Professionals. Specific	cally, the Para				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		MHL036-336	B. WING		09/2	29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIP CODE		
			JNTINGTON DRIV			
FRESH NE	EW START		NIA, NC 28056			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		- Arr.
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
V 293	Continued From pag	ne 63	V 293			
		eive training by a qualified lays of hire or return to work:				
	8. technical knowled					
	cultural awarenes					
	10. analytical skills;	56,				
	11. decision-making;					
	12. interpersonal skil					
	13. communication s	kills; and				
14. clinical skills.  V111&V112: Fresh New Start will comply with all						
		NCAC 27G .0205 including:				
		uirement that an admission				
		completed for all consumers				
	prior to the delivery of	services, that includes, but				
	not be limited to:					
	<ol> <li>the client's preser</li> </ol>					
	2. the client's needs					
		dmitting diagnosis with an				
	days of	s determined within 30				
	(37)	t that a client admitted to a				
		r 24-hour medical program				
	shall have an establis					
	admission;					
	<ol><li>a pertinent social, and</li></ol>	family, and medical history;				
	6. evaluations or ass	sessments, such as				
	psychiatric, substance	e abuse, medical,				
	and vocational, as					
	7. appropriate to the					
		uirement that a Person-				
		reloped prior to starting strategies to address the				
	client's presenting pro					
		equired in 10A NCAC 27G				
	.0205(d)(1-6).					
	V118: Fresh New Star requirements of 10A N	t will comply with all ICAC 271g .0209 including				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/:	29/2020
	ROVIDER OR SUPPLIER	4460 HUI	ODRESS, CITY, STANTINGTON DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	training by qualified training by qualified training and labeling b. Medication admired. Medication Storage. Medication review f. Medication erview f. Medication tradition, the agency procedure to ensure it required elements. All be trained in its require professional, e.g. a redealing with medication will contract with a meoversee its medication professional will conducted record at least self-audits will be kept vital: Fresh New Starrequirements of GS 1 the requirement that a Care Personnel Regis Specifically, the agency requirements of GS 1: requirement that all st record check on file. Specifically, the agency record checks on all new filters.	e staff have documented ainer in the following topics: asing: Medication packaging distration sal ge witton  y will update its policy and as procedures include all new and returning staff will ements by a medical gistered nurse, prior to ans. In addition, the agency dical professional to a practices. The medical puct self-audits of medication monthly. The result of the con file.  In the will comply with all staff have a Health stry check on file.  The will conduct Health stry check on all new and ire/return and annually self-audited on a quarterly fance with this standard.  The will comply with all 22C-80 including the	V 293			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
FRESH N	EW START		JNTINGTON DRIV	E		
			NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From pag	e 65	V 293			
V 293	that has not lived in N past 5 consecutive ye Bureau of Investigation The agency will follow 122C-80(c-e) when make decisions.  Personnel files will be basis to ensure composition basis to ensure composition of 10A I Enforcing the requirements of 10A I Enforcing the requirement a. A qualified profestelephone or page. A to reach the facility with b. The minimum number of the present and awake is 1. two direct care states two, three or four child agency will interpret include a requirement consumer is in the costaff shall be present V297: Fresh New Starrequirements of 10A N a. Enforcing the requirements of 10A N a. Enforcing the require	IC (North Carolina) for the ears will have a SBI (State ons) criminal record check. It the requirements of § naking hiring/retention  e self-audited on a quarterly diance with this standard.  It will comply with all NCAC 27G .1704 including: ments that: sional shall be available by direct care staff will be able thin 30 minutes at all times mber of direct care staff en or adolescents are as follows: aff shall be present for one, dren or adolescents; The IOA NCAC 27G .1704(b) to that if a (singular) mmunity with staff that two with the consumer.  It will comply with all ICAC 27G .1705 including: irrement that a licensed or sional, e.g. LCSW iial Worker), LPC all Counselor), LMFT and Family Therapist), the, Psychologist, issent on site a minimum of	V 293			
	<ol> <li>The licensed profe and out at the facility.</li> <li>will be kept in the reco</li> <li>The licensed profe</li> <li>Documented month</li> </ol>	The sign in/out sheet ord. essional will provide:				

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Division of Health Service Regulation

DIVISION	or ricality oct vice regu	iation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		2011	20,000	
		WITE030-330			09/2	29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
EDECH NI	EW START	4460 HU	NTINGTON DR	IVE			
TRESTIN	LWSTART	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293	in Rule .1702; ii. Individual, group or iii. Involvement in chi treatment plans or ove b. As permitted by N therapy or activity time time per beneficiary (i members in a group fc counted as 90 minute.  V364: Fresh New Star requirements of GS (G including GS 122C-62(agency to enforce the minor client who is rece habilitation in a 24-hou Make and receive conf extraordinary circumsta this right to be curtailed 122C-62(e) are met. § right enumerated in sul section may be limited qualified professional re formulation of the client plan. A written stateme client's record that indic the restriction. The rest and related to the client needs. A restriction is e exceed 30 days. An ev shall be conducted by t	alified professional specified or family therapy services; all dor adolescent specific erall program issues.  C DMA CCP 8D2- "Group eray be included as total eray be included as total eray be included as total eray be may be included as total eray of minutes, this may be so per beneficiary)."  It will comply with all deneral Statute) 122C-62 (d)(1) that requires the requirement that " each eliving treatment or racility has the right to: (1) fidential telephone calls." In ences § 122C-62(b) allows the fither equirements of § 122C-62(e) states that " No besections (b) or (d) of this or restricted except by the esponsible for the the treatment or habilitation and shall be placed in the cates the detailed reason for riction shall be reasonable the treatment or habilitation effective for a period not to aluation of each restriction the qualified professional at	V 293	, DEFICIENCY)			
	least every seven days restriction may be remore restriction shall be docurecord. Restrictions on only by a written statem qualified professional in	oved. Each evaluation of a nmented in the client's rights may be renewed nent entered by the					

qualified professional in

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1					
AND PLAN OF CORRECTION	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND I BIT OF GONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP	PLETED
	MHL036-336	B. WING		09/2	29/2020
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
FRESH NEW START	4460 H	UNTINGTON DRIV	'E		
	GASTO	NIA, NC 28056			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
the client's record that st renewal of the restriction comply with this requirem. To provide an extra layer consumer's right any such modification shall be appr agency's Clients Rights B. Committee and the legally. The agency's Policy and F. consumer rights, person-c. Clients Rights Behavioral around this matter shall be ensure clarity on this matt.  V366:: Fresh New Start w requirements of 10A NCAC a. Ensuring that all Level reported to DHSR (Divisio Regulation) and the LME/I Management Entity/Manages required by the prevailing (Department of Health and Incident Reporting System and 10A NCAC 27g .0604 b. The agency will keep file for inspection for gove c. New hires and returning retrained in incident report and annually thereafter. d. The agency will conduself-audits to ensure this sincluding cross walking Leginotes to incident reports.  V367 Fresh New Start will requirements of 10A NCAC Cross reference to resport to V366.  V536: Fresh New Start will requirements of 10A NCAC Cross reference to resport to V366.	ates the reason for the ." The agency will nent. of ensuring the n Person-Centered Plan oved in writing by the ehavioral Intervention or responsible person. Procedure around centered planning, and Intervention Committee e reviewed/updated to er.  ill comply with all C 27g .0603 including: Ill and III incidents are n of Health Service MCO (Local ged Care Organization) ng NC DHHS d Human Services) n (IRIS) within the IRIS stipulated timeframes. all incident reports on rmmental authorities. ng staff will be ting prior to hire/return  ct at least quarterly tandard is met vel I,II, & III progress  I comply with all C 27g .0604 nse to response	V 293			

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	B. WING		09/29/2020
ME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
ESH NEW START	4460 HI	JNTINGTON DRIVI	E	
-51111211 5171111	GASTO	NIA, NC 28056		
EFIX (EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
a. The agency will of Alternatives To Restrict that all staff must comple as defined in NCAC 276 will a curriculum approvement. The agency will erreturning staff have valid To Restrictive Intervention before working and annual c. The agency will conself-audits to ensure this v537: Fresh New Start requirements of NCAC Cross reference to responding that all states are requirements of 10A NC a. Ensuring that all states are requirements of 10A NC a. Ensuring that all states are responding to the clients served supports that prespectful environment. a. using the least research and b. promoting coping at that are alternatives to it or others; c. providing choices to the clients served/supd. sharing of control of client/legally responsible e. The use of a restriprocedure designed to rishall always be accompful designed to insured during and after the integuire will be suited to the clients and after the integuire using the intervent	CAC 27E .0107 including: noose one Training On ive Interventions curricula lete by a qualified trainer E .0108 . The curriculum red by the NC Itist of approved curricula. Insure all newly hired and d Training On Alternatives ions certificate on file ually thereafter. Induct at least quarterly Is standard is met.  Inwill comply with all 27E .0108. Insure all newly hired and Itist comply with all Itist comply with al	V 293		

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		00/00/0000		
					1 09/	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST.				
FRESH N	EW START		INTINGTON DRI	VE			
(1/1) IP	CHAMAADVCT		NIA, NC 28056				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293	Continued From page	e 69	V 293				
	V536 and V537						
	V541: Fresh New Sta	art will comply with all					
		NCAC 27F .0104 including					
		fforts to ensure consumers'					
	from theft, damage, o	possessions are safe					
	misplacement. This w	: : : : : : : : : : : : : : : : : : :					
	limited to, assisting th	ne client in developing and					
	maintaining an invent						
		s if the client or legally esires. To facilitate this the					
agency will take an inve possessions upon admi- a case by case basis pri visit. In the event a cons							
		mission, discharge and on					
		prior to and after a home					
		pehind the item will mail to e person within 7 days of					
	discovery.	percent within a days of					
	Describe your plans to	o make sure the					
above happens.  As noted in the prean not have any residen facility. To ensure con							
		npliance with this Plan of					
		any subsequent Plan of					
	Correction (POC) the						
	actions noted in the al						
		i, the agency will take the ake sure the POP and any					
	subsequent POC are						
	a. Contract with a Ce	rtified Forensic					
	Health Care Auditor for						
		self-audits of the agency to					
	sure compliance with						
	record.	self-audits will be in the					
		rship about compliance					
	matters.						
3. Consult with Client Ri		Rights Behavioral					

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STATEMENT OF DEFICIENCIES AND PLAN OF 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 PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, S	TATE, ZIP CODE		
FRESH N	EW START	4460 HU	NTINGTON DR	RIVE		
		GASTON	NA, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	or live online. The initiand available to playth and annual retraining 5. Conduct compete Qualified Professional live or live online. The recorded and available staff hires and annual b. The agency will not the facility until such the POP are fully in the POP are fully in Review on 9/29/20 of the Protection dated 9/29/2 #1/Director/Qualified Fill what immediate action ensure the safety of the At this time, Fresh Nehave any residents or facility. That being saitake the following actionsumers in its care care staff return to the V108: Fresh New Star comply with all requires .0202 including:  e. Enforcing the required applicants for employr criminal conviction.  f. A file shall be main	with newly hired and this POP and any e initial training will be live ital training will be recorded back for future staff hires.  Incy-based training with the initial training will be explained in training will be to playback for future tretraining. In the as all the actions in ime as all the actions i	V 293			
	employee indicating the and other	is training, experience				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:			
			MHL036-336	B. WING		09/29/2020		
NA	ME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIP CODE			
				INTINGTON DRIV				
FR	RESH N	EW START	GASTO	NIA, NC 28056				
(X	(4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		- Over	-
PF	REFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
		20						_
	V 293	Continued From page 71		V 293				
		g. qualifications for the position, including						
		verification of licensure, registration or						
		certification.						
h. Employee training pr								
	provided and, at a minimum, shall consist of the following:							
			ional orientation:					-
	<ul><li>(1) general organizational orientation;</li><li>(2) training on client rights and confidentiality</li></ul>							
			AC 27C, 27D, 27E, 27F and					
<ul><li>(3) 10A NCAC 26B;</li><li>(4) training to meet the mh/c</li><li>Health/Developmental Disab</li><li>Abuse) needs of the client as</li></ul>		, ,						
		and the second s	5.					
	the treatment/habilitation plan; and (5) training in infectious diseases and bloodborne pathogens.							
Specifically, the agency will re								
	returning staff to have new background chec							
prior to starting work* and								
	based training in Item D (1- prior to starting work. All p audited to ensure complian					190		l
			onal information on last					
		page regarding training dates)						
		V109: Brighter Dayz (Licensee/Sister Facility A)						
			uirements of 10A NCAC					
			nsuring the competency					
			sional. Specifically, the will receive training by a					
		qualified trainer by 10/	0 ,					
		15. technical knowledge						
		16. cultural awareness;						
		17. analytical skills;						
		18. decision-making;						
		19. interpersonal skills						
		<ol> <li>communication ski</li> <li>clinical skills.</li> </ol>	iis; and					
		Z I. UIIIIUdi SKIIIS.						
	V110: Brighter Dayz will comply with all							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Account to consider a constant	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY PLETED
		MHL036-336	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDDESS CITY OF	ATE 710 0005	03/.	23/2020
TVANIE OF T	NOVIDEN ON SUPPLIER		ADDRESS, CITY, ST JNTINGTON DRI			
FRESH N	EW START		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	ensuring the competer Professionals. Specificationals. Specificati	NCAC 27G .0204 including ancy of the Para cally, newly hired and sionals will receive training prior to starting work. Ige; s;	V 293			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		na	29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDDESS SITY STAT	F. 710.000F	09/	29/2020
NAME OF FI	NOVIDER OR SUFFLIER		ADDRESS, CITY, STAT UNTINGTON DRIV			
FRESH N	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From pag	ge 73	V 293			
	have documented tra the following topics p h. Medication disper and labeling i. Medication admir j. Medication Stora l. Medication review m. Medication educa n. Medication errors In addition, the agenc procedure to ensure i required elements. Al be trained in its requir professional, e.g. a re dealing with medicatio will contract with a me oversee its medication professional will cond related record at least self-audits will be kep  V131: Fresh New Sta requirement that a Care Personnel Regis Specifically, the agen Care Personnel Regis returning staff upon h thereafter. Personnel files will be basis to ensure compl	NCAC 271g .0209 ewly hired or returning staff aining by qualified trainer in orior to working: nsing: Medication packaging nistration sal ge v ation sy will update its policy and ts procedures include all I new and returning staff will rements by a medical registered nurse, prior to ons. In addition, the agency edical professional to n practices. The medical uct self-audits of medication it monthly. The result of the t on file.  art will comply with all 31E-256 including all staff have a Health				
		122C-80 including the aff have a criminal record				

	9					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same and the s	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		1	
		MHL036-336	B. WING		000	20/2020
NAME OF D	ROVIDER OR SUPPLIER	1	ADDDESS SITU STA	TF 710 000 F	09/	29/2020
NAME OF FI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA JNTINGTON DRIV			
FRESH N	EW START		NIA, NC 28056			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S DI ANI OF CORRECTION	7	T
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	e 74	V 293			
	74 (20) (20)		1200			
	check on file.	overvill according to the				
	Specifically, the agen	s on all new and returning				
	staff prior upon hire/re					
		nat has not lived in NC for				
		e years will have a SBI				
		. The agency will follow the				
	requirements of § 122	2C-80(c-e) when making				
	hiring/retention decision					
		self-audited on a quarterly				
	basis to ensure comp	liance with this standard.				
	V296: Fresh New Star	rt will comply with all				
		NCAC 27G .1704 including:				
	Enforcing the requiren					
		sional shall be available by				
		direct care staff will be able				
		hin 30 minutes at all times				
		nber of direct care staff				
	required when childre					
	present and awake is					
		ff shall be present for one, ren or adolescents; The				
		DA NCAC 27G .1704(b) to			9	
	include a requirement					
	the country of the country and the country of the c	nmunity with staff that two				
	staff shall be present v					
	V207: Fresh Now Ct-	t will comply with -!!				
	V297: Fresh New Start	CAC 27G .1705 including:				
		irement that a licensed or				
	associate level profess					
	(Licensed Clinical Soci					
	(Licensed Professiona					
	(Licensed Marriage an					
	Psychological Associa	te, Psychologist,				
		sent on site a minimum of				
	4 hours per week. Spe					
		ssional shall sign in and				
	out at the facility. The s	sign in/out sheet will be				

	3-	TOTIOTI				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	Table 1100	
FRESH N	EW START		JNTINGTON DRIV	'E		
			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	e 75	V 293			
	kept in the record.  2. The licensed professional will provide: i. Documented monthly formal clinical 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. c. 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 tes, this may be counted as				
	including GS 122C-62 agency to enforce the minor client who is rechabilitation in a 24-hou	Seneral Statute) 122C-62 (d)(1) that requires the requirement that "each				
	of § 122C-62(e) are me "No right enumerated this section may be lim the qualified profession	urtailed if the requirements et. § 122C-62(e) states that in subsections (b) or (d) of ited or restricted except by nal responsible for the				
	plan. A written stateme client's record that indic for the restriction. The reasonable and related habilitation needs. A re period not to exceed 30 each restriction shall be	to the client's treatment or striction is effective for a days. An evaluation of econducted by the qualified ery seven days, at which be removed. Each				

Division of Health Service Regulation

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING	B. WING		29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
FRESHN	EW START		INTINGTON DRIV	E			
			NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293	Continued From page	e 76	V 293				
	documented in the cl on rights may be rene statement entered by in the client's record to the renewal of the res- comply with this requival. To provide an extra la consumer's right any se modification shall be a agency's Clients Right Committee and the leg The agency's Policy at consumer rights, perso Clients Rights Behavious around this matter shall ensure clarity on this in	ient's record. Restrictions ewed only by a written the qualified professional that states the reason for striction." The agency will irement.  Eyer of ensuring the such Person-Centered Plan approved in writing by the is Behavioral Intervention gally responsible person. In the Procedure around concentered planning, and oral Intervention Committee all be reviewed/updated to matter.	V 293				
	reported to DHSR and by the prevailing NC D Department of Health a Incident Reporting Sys and 10A NCAC 27g .0 f. The agency will ke file for inspection for g g. New hires and reture trained in incident reand annually thereafted. The agency will conself-audits to ensure the	the LME/MCO as required HHS (North Carolina and Human Services) atem (IRIS) within the IRIS 604 stipulated timeframes. Seep all incident reports on overnmental authorities. Turning staff will be aporting prior to hire/return er. Induct at least quarterly his standard is met g Level I,II, & III progress is.  will comply with all ICAC 27g .0604					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL036-336	B. WING		09/	29/2020	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE ZIR CODE		20/2020	
2.55.2		UNTINGTON DRIV				
FRESH NEW START		NIA, NC 28056				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ( CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293 Continued From page	2 77	V 293				
V536: Fresh New Star requirements of 10A N d. The agency will of Alternatives To Restrict that all staff must come as defined in NCAC 2 will a curriculum approximate DMH/IDD/SAS (Depart Health/Intellectual Devalum Disability/Substance A of approved curricula. e. The agency will erreturning staff have valued To Restrictive Intervent before prior to working for the agency will conself-audits to ensure the V537: Fresh New Start requirements of NCAC Cross reference to results of 10A Notes. Ensuring that all state of 10A Notes are substantially respectful environment and using the least results appropriate settings are burned provided by promoting coping that are alternatives to or others; c. providing choices the clients served/supprince of the start of the served/supprince in the served of th	t will comply with all ICAC 27E .0107 including: shoose one Training On ctive Interventions curricula uplete by a qualified trainer 7E .0108. The curriculum oved by the NC rtment of Mental velopmental Abuse Services) on their list insure all newly hired and lid Training On Alternatives tions certificate on file and annually thereafter. onduct at least quarterly his standard is met.  It will comply with all C27E .0108. Sponse to V536.  It will comply with all CAC 27E .0101 including; taff will provide promote a safe and and methods; and engagement skills injurious behavior to self of activities meaningful to corted; and over decisions with the e person and staff. Ictive intervention	V 293				

Division of Health Service Regulation

6899

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY MPLETED
		MHL036-336	B. WING		09	/29/2020
	ROVIDER OR SUPPLIER	4460 HL	ADDRESS, CITY, STA INTINGTON DRIV NIA, NC 28056			23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETE DATE
V 293	and after the intervent g. using the intervent d. employing the intervent to V536 and V537  V541: Fresh New Starequirements of 10A making reasonable erconsumers' personal are safe from theft, da and misplacement. The limited to, assisting the maintaining an invent personal possessions responsible person deagency will take an inpossessions upon additional a case by case basis visit. In the event a colleaves a possession the legally responsible discovery.  Describe your plans to above happens.  As noted in the pream does not have any resin this facility. To ensure the protection (PC) Plan of Correction (PC) Plan of Correction (PC) Plan of Correction (PC) the actions noted in the responses. In addition following actions to many subsequent POC c. Contract with a Cellealth Care Auditor for	e dignity and respect during ion. These include: stion as a last resort; and ervention only by people is reference to response out will comply with all NCAC 27F .0104 including forts to ensure clothing and possessions amage, destruction, loss, his will include, but is not be client in developing and cory of clothing and cory of clothing and cory of clothing and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of clothing to an after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes and mission, discharge and on prior to and after a home consumer is discharged and cory of all clothes	V 293			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
	MHL036-336	B. WING		09/29/2020
NAME OF PROVIDER OR SUPPLIER	-	ADDRESS, CITY, STAT	TE ZIR CODE	09/29/2020
		UNTINGTON DRIV		
FRESH NEW START	GASTO	NIA, NC 28056		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
the record.  7. Consult with lear matters.  8. Consult with Cli Intervention Comming.  9. Conduct training returning staff about subsequent POC pri training will be live or will be recorded and future staff hires and 10. Conduct compet Qualified Profession training will be live or will be recorded and future staff hires and d. The agency will the facility until such in the POP are fully.  Additional Information Regarding training deprofessional will be the 10/18/20. However, and off all direct care staff rehire staff. Therefore concrete date Associatiff will be trained or receive all required to the Regarding Certified Filed Internal Fore a Masters in Humans thirty plus years of existing the staff of the professional staff will be trained to receive all required to the staff of the professional staff will be trained to receive all required to the staff of the professional staff of the profession	The self-audits will be in ordership about compliance ent Rights Behavioral littee with newly hired and this POP and any for to staff working. The initial relive online. The initial training available to playback for annual retraining. ency-based training with the all by 10/18/20. The initial relive online. The initial training available to playback for annual retraining. In the as all the actions implemented.  On: ates- The Qualified rained by [Consultant] by at present the facility has laid if and will need to hire or equit is not possible to give a liate and Para-Professional ther than to say that they will raining PRIOR to working.  Healthcare Auditor-ertified Internal Forensic Consultant] is certified by the Healthcare Compliance	V 293	DEFICIENCY)	

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Division of Health Service Regulation

	of ricality octated ricage	nation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIR CODE		
			UNTINGTON DRIVI			
FRESHN	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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	agencies including tw (high level) experience and compliance.  [Consultant] is a lead surveyor for the Accre Health Care and cons accreditation standard regional performance program and the Nort and Community Base executive officer of a re that provided a wide a  [Consultant] is a Perso Illness Management a Specialist, and Essent trainer. He is a former [College] in their Maste centered planning and his company's website  When [Consultant]'s o Qualified Professiona of monitoring complia any subsequent POC  Regarding training date Professional will be tra 10/18/20. However, at off all direct care staff a rehire staff. Therefore, concrete date Associal staff will be trained other receive all required train  Former Client #1 was	behavioral healthcare editation Commission for ulted in the development of ds. He has overseen the of a class action lawsuit h Carolina Medicaid Home d Waiver. He has been an multi-state provider agency array of services.  On-Centered Thinking, and Recovery, Peer Support ial Lifestyle Planning Field Faculty Adviser with er's program for personal systems change. Here is expressed in the facility has laid and will need to hire or it is not possible to give a te and Para Professional er than to say that they will ning PRIOR to working."	V 293			

Division of Health Service Regulation

STATE FORM S6LM11 If continuation sheet 81 of 132

	IENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	(AL) MOCINICE CONTOURS		(X3) DATE SURVEY	
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED	
		MHL036-336	B. WING		09/2	29/2020	
NAME O	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE			
FRESH	NEW START	4460 H	UNTINGTON DRIV	E			
		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 OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 29	destruction, rage, por sexualized activity whossible sexualized be to 5 behavioral outbut #2 was 9 years old an Traumatic Stress Disc Hyperactivity Disorde property destruction, sexually molested at Former Client #3 was diagnosed with Attent Disorder, Post Traum Oppositional Defiant I She had a history of rear with unknown mal behaviors, and aggres 13 years old and was Oppositional Defiant I Trauma. She had a hidestruction, physical abehaviors, sexual abuallegations of abuse. Fyears old and was dia Traumatic Stress Disconstruction Disorder Trauma. She had a hidestruction Disorder Trauma and auditory command. The facility did not cor assessments inclusive needs and strengths, diagnosis, and pertine medical history for Fo and #5. There was no completed for Former the facility did not devindividualized treatme	or hygiene, discussing mile at day camp and behaviors in the past, with 4 rests weekly. Former Client and was diagnosed with Post order and Attention Deficit r. She had a history of self-harm, and had been the age of 5 or 6 years old.  13 years old and was ion Deficit Hyperactivity atic Stress Disorder, Disorder, and Depression. Journing away, getting in the es, increased sexual sesion. Former Client #4 was diagnosed with Disorder and Unspecified story of property assault, sexualized se/rape, and false former Client #5 was 10 gnosed with Post order, Disruptive Mood er, and Unspecified story of anger, aggression, ds.  Implete admission and of presenting problem, provisional or admitting ent social, family, and remer Clients #1, #3, #4, admission assessment Client #2. Furthermore, elop and implement int plans reflecting the	V 293	DEFICIENCY)			
	functional deficits of the	ne clients. There were no ne place when clients ran					

	or reducer oct vioc rege	alditori				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY MPLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE ZIP CODE		
			UNTINGTON DRIV			
FRESH	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 293	behavior, or displayed behaviors. Former Clattended various sum were no treatment strathese camps. Former failed to maintain plate due to their assaultive. The facility did not enstaff to meet the need training in human sex aggressive behaviors training for three staff questionable. One statrained in Alternatives and Physical Restrain Time-Out. Health Carcriminal background on all staff. Furtherm not protected after arcommitted by Staff #8.  The facility was not opmanner. Staff used protected after arcommitted by Staff #8.  The facility was not opmanner. Staff used protected her has Former Client #3. The clients privacy on teleguardians. There were the services of the Lienter professional/Qualified Furthermore, the facility ratios to ensure super resulting in multiple be occurring at least week victim of sexual moles sexually victimized by playtime in a bedroom #3, both having their of the services of the victim of sexual moles sexually victimized by playtime in a bedroom #3, both having their of the services of the victim and bedroom #3, both having their of the services of the victim and bedroom #3, both having their of the services of the victim and bedroom #3, both having their of the services of the victim and bedroom #3, both having their of the services of the victim and bedroom #3.	d sexually inappropriate lients #1, #3, and #4 mer day camps but there rategies to reflect the use of a Clients #1, #3, and #4 all cement at the day camps to or sexualized behaviors.  Sure proper training for the discontinuous sure proper training for the discontinuous discontinuou	V 293			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED		
		MHL036-336	B. WING	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
FRESH N	EW START		NTINGTON DE	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ! CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293	At the time of the ass were in the common not providing propers reporting was not corpersonal property was returned to them immunities and the professional property was returned to them immunities and the professional property was returned to them immunities and property was returned to them immunities and professional professio	ault, both staff members area of the home and were supervision. Incident impleted. Former clients' is not protected and rediately at discharge.  Qualified Professional sutive Director, Licensed if Professional #2 and al failed to provide the resulting in clients not quired.  Lutes a Type A1 rule rum and neglect. An of \$2,000.00 is imposed.  Lattraction Tx. Child/Adol -  MINIMUM STAFFING sional shall be available a direct care staff shall acility within 30 minutes is as follows: re staff shall be present for children or adolescents; are staff shall be present regist children or restaff shall be present restaff shall shall be present restaff shall sh	V 293	V 296 The agency will comply with all requirer 10A NCAC 27G .1704 including: Enforcing the requirements that:  a. A qualified professional shall be available by telephone or page care staff will be able to reach facility within 30 minutes at all b. The minimum number of direct staff required when children or adolescents are present and awas follows:  1. two direct care staff sl present for one, two, to four children or adoles The agency will interpret 10A NCAC 27G .1704(b) to include a requirement that if (singular) consumer is in the community staff that two staff shall be present with consumer	e. A direct the times care vake is hall be three or scents;	10/22/220	

Division of Health Service Regulation

6899

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S:		MPLETED
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		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S			
FRESH N	EW START		INTINGTON DF NIA, NC 28056	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	during child or adolesce as follows:  (1) two direct ca and one shall be awak children or adolescents  (2) two direct ca and both shall be awak children or adolescents  (3) three direct of which two shall be as be asleep for nine, ten or adolescents.  (d) In addition to their direct care staff set for of this Rule, more direct required in the facility be adolescent's individual the treatment plan.  (e) Each facility shall be supervision of children are away from the facility child or adolescent's inconeeds as specified in the supervision, the facility care staff when one, two were present and failed clients when they were	cent sleep hours is  are staff shall be present e for one through four s; are staff shall be present de for five through eight s; and care staff shall be present de wake and the third may g, eleven or twelve children  minimum number of th in Paragraphs (a)-(c) ct care staff shall be coased on the child or aneeds as specified in  the responsible for ensuring or adolescents when they ty in accordance with the dividual strengths and the treatment plan.  The evidenced by: ord review, and failed to ensure two direct to, three, or four clients to ensure supervision of away from the facility lients (Former Clients #1,	V 296	V 296 Con't The agency will maintain all work logs, records and staffing calendars in perper DHSR inspection.	payroll tuity for	
	Review on 8/11/20, 8/1	2/20 and 8/18/20 of				

	or reality con moor togo	ration				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		0.9	29/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE. ZIP CODE		
EDESH N	EW START		INTINGTON DRIV			
TRESITA	LWSTART	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 296	Continued From page	85	V 296			
	Former Client #1's red-Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disrud Disorder and Attention Disorder; -11 years old; -History of assault, propoor hygiene, discuss at day camp and poss the past, with 4 to 5 between the past, with 4	aptive Mood Dysregulation a Deficit Hyperactivity  Deperty destruction, rage, ing sexualized activity while ible sexualized behaviors in chavioral outbursts weekly.  12/20 and 8/18/20 of ord revealed:  Traumatic Stress Disorder hyperactivity Disorder; struction and self-harm.  12/20 and 8/18/20 of ord revealed:  Ition Deficit Hyperactivity htic Stress Disorder, isorder, Depression; ay, getting in the car with ased sexual behaviors, and  12/20 and 8/18/20 of ord revealed:  Ition Deficit Hyperactivity htic Stress Disorder, isorder, Depression; ay, getting in the car with ased sexual behaviors, and	V 296			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION 5:		DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE			
FRESHN	EW START		INTINGTON DE NIA, NC 28056	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
	sexualized behaviors, false allegations of abuth Review on 8/11/20, 8/Former Client #5's red-Admitted 8/5/20; -Discharged 8/7/20; -Discharged 8/7/20; -Diagnosed with Post Disruptive Mood Dysre Unspecified Trauma; -10 years old; -History of anger, aggreommands.  Review on 8/13/20 of Reports dated 7/1/20 - Incident Report dated altercation between For Client #A1 witnessed It park. There was no do staff present.  Interviews on 8/14/20 with Former Client #A1—There was one staff present but so matter clients' behaviors.  Interviews on 9/2/20-9/members at the local recolumner day camp reveals and staff present and Former Client #1 and Fo	struction, physical assault, sexual abuse/rape, and use.  12/20 and 8/18/20 of ford revealed:  Traumatic Stress Disorder, and ression, and auditory  the facility's Incident - Level I 7/22/20 involved a physical former Client #3 and Former by Staff #5 while in the focumentation of a second with Former Client ay camp at a local a neighboring town; resent at the facility supposed to be two my staff quit because of 4/20 with management ecreational facility Former Client #A1 attended	V 296				

	9						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE		
		MHL036-336	B. WING		09	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE			
FRESH N	EW START	4460 HI	JNTINGTON DRIV	E			
		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 296	Continued From pag	ne 87	V 296				
	2nd shift.  Interview on 9/3/20 v revealed: -Attended a summer not allowed to stay in the director of the surthat Former Client #3 altercation with Form Former Client #A1 state throat; -"I could not go back to stabbed me in the thr I fought her back;" -One or two staff workstaff worked at lunch one staff worked at night I	vith Former Client #3 cheerleading camp; -Was a camp all summer when mmer camp discovered					
	#3's Department of S Social Worker revealed -Had multiple concern Client #3 attended a control of the DSS Social Worker middle of July, 2020. informed she could no	ed:  ns with the facility; -Former cheerleading camp which er found out about in the Former Client #3 was of return to camp due to a a staff at the camp; -Never on regarding what					
	Adoption Recruiter rev	with Former Client #3's vealed: ended three different camps					

ALSO-LIMITED RESIDENCE THE TORSESSESSESSESSESSESSESSESSESSESSESSESSES	ENTIFICATION NUMBER:	A BUILDING		(X3) DATE SURVEY COMPLETED	
		A. BUILDING			
	MHL036-336	B. WING		09/2	29/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
FRESH NEW START	4460 HUN	TINGTON DRI	VE		
	GASTONIA	A, NC 28056			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 296 Continued From page 88 because she was moved from due to her behaviors.  Interview on 8/12/20 with Former Client #3 was kicked camp because of her behaviors.  Former Client #4 was kicked camp for kissing boys; Former Client #1 attended so camp; -Was in a peer's bedroin sexualized behaviors with estaff usually worked alone; 90% of the time there was journed to work.  Interview on 8/12/20 with Former Clients from the facility; Staff would get fired or quite to work.  Interview on 8/12/20 with Former Clients from the facility to summer day camps.  Interview on 8/25/20 with Former Clients from the facility to summer day camps.  Interview on 8/25/20 with Former Clients from the facility to summer day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.  Interview on 8/25/20 with Former Clients from the day camps.	ormer Client  ad out of summer day  viors; ad out of summer day  summer day  soom and engaged  Former Client #2;  just one staff at  or would not come  ormer Client #4's  d: by were sent  ormer Client  aytime and only one  ows this because  ernight shift.  11/20 at  taff #5 revealed:  peaker phone pering could be  ff #5 hesitated prior  #5 was asked if  during the interview.	V 296			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S	
			A. BOILDIN	O.		
		MHL036-336	B. WING		09/2	9/2020
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
FRESH N	EW START		HUNTINGTON D			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ONIA, NC 28056	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETE DATE
V 296	Continued From page	e 89	V 296			
	Interview on 9/21/20 revealed: -Two staff worked pe	with Associate Professional r shift.				
	Interview on 9/11/20 w - "Two staff to four clie					
V 297	Staff #12 revealed: -Only one staff preser -Was often left with cli and Sister Facility A; -Worked alone on 7/6 facility and Sister Facility and S	with Licensee Professional #1 and e Director revealed: o staff per shift. es referenced into 10A ope (V293) for a Type al Tx. Child/Adol - Req. for	V 297	V 297 The agency will comply with all requirem 10A NCAC 27G .1705 including:  a. Enforcing the requirement that a	nents of	0/22/220
	this Rule, licensed proindividual who holds a license issued by the ga human service profes	SIONALS Il consultation shall be y at least four hours a ofessional. For purposes of fessional means an license or provisional overning board regulating ssion in the State of North e-related disorders this Il Clinical Addiction	OF	a. Enforcing the requirement that a licensed or associate level profe e.g. LCSW, LPC, LMFT, Psychologist, Psychia will be present on site a minimur hours per week. Specifically:  1. The licensed profession shall sign in and out at facility. The sign in/out will be kept in the record	essional, blogical atrist m of 4 nal the sheet	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  COMPLIANCE  COMPLIANCE  B. WING	LETED
R WING	
MHL036-336 B. WING 09/29	9/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
FRESH NEW START 4460 HUNTINGTON DRIVE	
GASTONIA, NC 28056	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 297 Continued From page 90 (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule 1:702 of this Saction; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues.  This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure face-to-face clinical consultation at least four hours per week with a licensed professional. The findings are:  Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #1's record revealed: -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder; -11 years old: -History of assault, property destruction, rage, poor hygiene, discussing sexualized activity while at day camp and possible sexualized behaviors in the past, with 4 to 5 behavioral outbursts weekly.  Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #2's record revealed: -Admitted 7/10/20; -Discharged 8/7/20; -Disgnosed with Post Traumalic Stress Disorder and Attention Deficit Hyperactivity Disorder; -1 years old: -1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
FRESHN	EW START		INTINGTON DRIV	E		
10000000000000000000000000000000000000	Γ		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	-9 years old; -History of property de Review on 8/11/20, 8/ Former Client #3's rec -Admitted 6/12/20; -Discharged 8/4/20; -Diagnosed with Atten Disorder, Post Trauma Oppositional Defiant E -13 years old; -History of running aw unknown males, increa aggression.  Review on 8/11/20, 8/ Former Client #4's rec -Admitted 4/24/20; -Discharged 8/6/20; -Diagnosed with Oppo and Unspecified Traum -13 years old; -History of property de sexualized behaviors, false allegations of abu Review on 8/11/20, 8/ Former Client #5's recc -Admitted 8/5/20; -Discharged 8/7/20;	estruction and self-harm.  12/20 and 8/18/20 of cord revealed:  Ition Deficit Hyperactivity atic Stress Disorder, Disorder, Depression;  ay, getting in the car with ased sexual behaviors, and  12/20 and 8/18/20 of ord revealed:  sitional Defiant Disorder na;  struction, physical assault, sexual abuse/rape, and use.  12/20 and 8/18/20 of ord revealed:  Italian assault assault, sexual abuse/rape, and use.  Italian assault assault, sexual abuse/rape, and use.  Italian assault assault, sexual abuse/rape, and use.  Italian assault assault, sexual abuse/rape, and use.	V 297			
17.	revealed: -The Licensed Professi	onal/Qualified				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
EDECT NI	EW START		JNTINGTON DRIV			
TICEOTTIV	LW 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	two weeks" for group Interview on 8/12/20 #2 revealed: -The Licensed Profes Professional #2 would Mondays and sometir week but Former Cliet how often the session Interview on 9/3/20 w revealed: -Would meet with the Professional/Qualified	sional/Qualified d complete sessions on mes on other days of the nt #2 could not remember s took place.  ith Former Client #3  Licensed Professional #2 but could the sessions would occur; ssional/Qualified a nice lady."				
	Professional/Qualified -Employed at the facilit since 2017; -Provided individual at twice weekly; -Used virtual sessions pandemic and resume in the beginning of Jul	on 9/10/20 at - 3:10pm with Licensed Professional #2 revealed: y and Sister Facility A  and group therapy during the start of the ed face to face sessions y; cility A was 9/2/20 when t #2 who was the only				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL036-336	B. WING		09/	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	re, zip code		
FRESH N	EW START	4460 HI	UNTINGTON DRIV	E		
		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 OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 297	Continued From page	e 93	V 297			
	the last date of service Client #2, the call was at 2:50pm; -Return calls to the L. Professional/Qualifier made immediately up call went to voicemail requesting a return ca-Call was returned by Professional/Qualifier went dead; -During the Professional/Qualifier she made a mistake a calendar correctly during the Former Client #2 was Facility A; -Will send copies of L. Professional/Qualifier via a secured and end	d Professional #2's phone on disconnection of the I and a message was left all; the Licensed d Professional #2 at I her cell phone battery he return call, the Licensed d Professional #2 revealed and did not view her ring the initial call. The last facility was 8/2/20 when the only client at Sister				
	#1, #2, #3, #4, and #5 discharge dates, there facility on 9/2/20 altho Professional/Qualified identified this as the la	e were no clients in the				
	that Former Clients #1 present in the facility of Licensed Professional identified only Former Review on 9/11/20 of e	1, #2, #3, and #4 were all on 8/2/20 although the l/Qualified Professional #2 Client #2's presence.  email correspondence to ulation (DHSR) surveyor				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION :		E SURVEY IPLETED
		MHL036-336	B. WING	09,		29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, ST	ATE, ZIP CODE		
FRESH N	EW START		ITINGTON DR IA, NC 28056	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE
V 297	Professional #2 dated revealed: "Good evening, I'm was conversation on this a work and do not fores requested documental I will have this informatomorrow night when not have access to the Review on 9/14/20 of to DHSR surveyor from Professional/Qualified 9/11/20 at 8:09pm revelucensed Professional #2's notes on Former sent via an attachment encrypted email; -No documentation of Professional/Qualified provided to Former Cl #A4.  Interview on 9/25/20 w#1/Director/Qualified Income #2/Executive Licensed Professional was at the facility weed Licensed Professional was at the facility weed Licensed Professional Professional was at the facility weed Licensed Professional	anted to follow up per our afternoon. I still currently at the being able to get you the ation this evening. However, ation to you no later than I come in from work as I do ese files."  I email correspondence of the Licensed of Professional #2 dated wealed:  al/Qualified Professional Clients #1 and #4 were of to a secure and  I Licensed Professional #2 services it to a secure and  I Licensed Professional #3, and  with Licensee Professional #1 and the Director revealed: -The I/Qualified Professional #2 akly. Sessions with the I/Qualified Professional #2 akly. Sessions with the I/Qualified Professional #2 akly during the start of the turned to in-person  as referenced into 10A	V 297			
V 364	G.S. 122C- 62 Additio Hour Facilities	nal Rights in 24	V 364			

DIVISION	of Fleatin Service Regu	lation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION G:	(X3) DATE COMP	SURVEY
		MHL036-336	B. WING		09/2	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
EDESH NI	EW START	4460 HL	INTINGTON DE	RIVE		
TRESTIN	LW START	GASTO	NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 364	client who is receiving in a 24-hour facility ke (1) Send and receive access to writing mat staff assistance where (2) Contact and consexpense and at no cocounsel, private physhealth, developments abuse professionals of (3) Contact and consthere is a client advoctory of the rights specified in restricted by the facility exercise these rights a (b) Except as provided of this section, each act treatment or habilitation times keeps the right to (1) Make and receive calls. All long distance by the client at the time made collect to the re (2) Receive visitors be a.m. and 9:00 p.m. for hours daily, two hours p.m.; however visiting over therapies; (3) Communicate and supervision with individual of the consent of the (4) Make visits outside unless:	rights enumerated in G.S. 5. 122C-61, each adult g treatment or habilitation eeps the right to: sealed mail and have erial, postage, and necessary; ult with, at his own est to the facility, legal icians, and private mental il disabilities, or substance of his choice; and ult with a client advocate if eate. this subsection may not be y and each adult client may it all reasonable times. d in subsections (e) and (h) dult client who is receiving in in a 24-hour facility at all o: confidential telephone e calls shall be paid for the of making the call or ceiving party; etween the hours of 8:00 a period of at least six of which shall be after 6:00 shall not take precedence meet under appropriate duals of his own choice	V 364	V 364 The agency will comply with all requirer GS 122C-62 including GS 122C-62(d)) requires the agency to enforce the required that "each minor client who is receivir treatment or habilitation in a 24-hour factor the right to: (1) Make and receive confict telephone calls."  In extraordinary circumstances § 122C-allows this right to be curtailed if the requirements of § 122C-62(e) are met. 62(e) states that "No right enumerated subsections (b) or (d) of this section malimited or restricted except by the qualifit professional responsible for the formular the client's treatment or habilitation plan written statement shall be placed in the record that indicates the detailed reason restriction. The restriction shall be reason and related to the client's treatment or habilitation needs. A restriction is effective period not to exceed 30 days. An evaluate each restriction shall be conducted by the qualified professional at least every several twhich time the restriction may be remediated in the client's record. Restrion rights may be renewed only by a writt statement entered by the qualified profession the client's record that states the reason the renewal of the restriction." The agency and the consumer's right any such Person-Center Plan modification shall be approved in whe agency's Clients Rights Behavioral Intervention Committee and the legally responsible person. The agency's Policy Procedure around consumer rights, person centered planning, and Clients Rights Belavioral Intervention Committee around this matter be reviewed/updated to ensure clarity on matter.	1) that irement regular properties of the control o	10/22/220

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL036-336	B. WING	B. WING		29/2020
NAME OF P	ROVIDER OR SUPPLIER		DDESS CITY S	TATE, ZIP CODE	09/	29/2020
			ITINGTON DR			
FRESHNI	EW START	GASTONI	A, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETE DATE
V 364	a violent crime, include an assault with a dearespondent was foun of insanity or incapable. The client was vocommitted to the facility committed to a corror of Public Safety; or c. The client is being capacity to proceed p. A court order may export of the conditions prescribed (5). Be out of doors defacilities and equipment several times a week; (6). Except as prohibiting and client is being held to proceed pursuant to G. (7). Participate in relig (8). Keep and spend a his own money; (9). Retain a driver's lie prohibited by Chapter Statutes; and (10). Have access to for his private use. (c). In addition to the ring to adult supervision and of the minor's status as a control of the control of the minor's status as a control of the contro	t's being charged with ding a crime involving dly weapon, and the d not guilty by reason ble of proceeding; luntarily admitted or ity while under order of ectional facility of the ection of the Department g held to determine cursuant to G.S. 15A-1002; pressly authorize visits by the existence of the by this subdivision; silly and have access to not for physical exercise ed by law, keep and use possessions, unless the determine capacity to G.S. 15A-1002; ious worship; reasonable sum of cense, unless otherwise 20 of the General or individual storage space ghts enumerated in G.S. 122C-61, each minor client who for habilitation in a 24-hour have access to proper guidance. In recognition of developing individual, the dopportunities to enable	V 364	V 364 Con't The agency will maintain Committee mi perpetuity for DHSR inspection.	nutes for	

	of Frounti Corvice racgo	idion				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY MPLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIR CODE		
			JNTINGTON DRIV			
FRESH	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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 364	emotionally, intellectuvocationally. In view of and intellectual immat hour facility shall provisupervision and contrigiven to the minor purfacility shall also, whereasonable efforts to eclient receives treatmer from adult clients unlet the minor client dictate Each minor client dictate Each minor client who habilitation from a 24-h (1). Communicate and or guardian or the age legal custody of him; (2). Contact and consexpense or that of his legally respond is or his legally respond is or his legally respond if there is a client advoor The rights specified in the restricted by the facility exercise these rights at (d). Except as provided of this section, each min treatment or habilitation the right to:  (1) Make and received distance calls shall be time of making the call receiving party; (2) Send and received	ally, socially, and of the physical, emotional, urity of the minor, the 24- ide appropriate structure, of consistent with the rights suant to this Part. The re practical, make ensure that each minor ent apart and separate ss the treatment needs of e otherwise. or is receiving treatment or four facility has the right to: and consult with his parents incur or individual having sult with, at his own egally responsible person cility, legal counsel, private intal health, developmental are abuse professionals, of insible person's choice; and sult with a client advocate, cate. this subsection may not be and each minor client may all reasonable times. d in subsections (e) and (h) inor client who is receiving in a 24-hour facility has et telephone calls. All long paid for by the client at the or made collect to the mail and have access to ge, and staff assistance	V 364			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/29/2020		
Personal and Personal Action Control of Cont	ROVIDER OR SUPPLIER	4460 HU	ADDRESS, CITY, STA				
		GASTO	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
	p.m. for a period of at hours of which shall be visiting shall not take period of at hours of which shall be visiting shall not take period training in accordance (5). Be out of doors of play, recreation, and pregular basis in accord (6). Except as prohib personal clothing and pappropriate supervision held to determine capa G.S. 15A-1002; (7). Participate in reli (8). Have access to for the safekeeping of (9). Have access to sum of his own money (10). Retain a driver's liprohibited by Chapter 2 (e). No right enumerat of this section may be by the qualified profess formulation of the client's record that indicting for the restriction. The reasonable and related habilitation needs. A reperiod not to exceed 30 each restriction shall be qualified professional at which time the restriction at which time the restriction of a redocumented in the clientights may be renewed.	cours of 8:00 a.m. and 9:00 least six hours daily, two after 6:00 p.m.; however precedence over school or education and vocational with federal and State law; daily and participate in physical exercise on a dance with his needs; ited by law, keep and use possessions under in, unless the client is being acity to proceed pursuant to gious worship; individual storage space personal belongings; and spend a reasonable of the General Statutes, and icense, unless otherwise 20 of the General Statutes, and in subsections (b) or (d) limited or restricted except sional responsible for the tris treatment or habilitation and shall be placed in the cates the detailed reason restriction is effective for a 20 days. An evaluation of the conducted by the the least every seven days, cition may be removed.	V 364				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING	B. WING		29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	03/	23/2020
FRESH N	EW START		NTINGTON DRIV	/E		
			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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	the client's record that renewal of the restrictic client who has not bee in each instance of an of a restriction of rights by the client shall, upon be notified of the restrictic. In the case of a mind adult client, the legally notified of each instance renewal of a restriction for it. Notification of the legally responsible perswriting in the client's remarked by the client's remarked by the facility affecting clients (Former Clients The findings are:  Review on 8/11/20 and #1's record revealed: -Admitted 12/27/19; -Discharged 8/6/20;	states the reason for the on. In the case of an adult in adjudicated incompetent, initial restriction or renewal is, an individual designated in the consent of the client, ction and of the reason for or client or an incompetent responsible person shall be see of an initial restriction or of rights and of the reason is designated individual or son shall be documented in cord.  Se evidenced by: deferord review, the facility function and consultation and or the agency or custody without restriction 5 of 5 audited former #1, #2, #3, #4, and #5).	V 364			
	Disorder and Attention Disorder; -11 years old.	otive Mood Dysregulation Deficit Hyperactivity  8/12/20 of Former Client				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA				
FRESH N	EW START		JNTINGTON DRIV	E			
	CUMMADVOT		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 364	Continued From page	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.  Review on 8/11/20 and 8/12/20 of Former Client						
	#3's record revealed: -Admitted 6/12/20;						
	<ul> <li>-Discharged 8/4/20;</li> <li>-Diagnosed with Attention Deficit Hyperactivity</li> <li>Disorder, Post Traumatic Stress Disorder,</li> <li>Oppositional Defiant Disorder, Depression;</li> <li>-13 years old.</li> </ul>						
	#4's record revealed: -Admitted 4/24/20; -Discharged 8/6/20;	d 8/12/20 of Former Client sitional Defiant Disorder na;					
	#5's record revealed: -Admitted 8/5/20; -Discharged 8/7/20;	8/12/20 of Former Client Fraumatic Stress Disorder, gulation Disorder, and					
		er grandparents but in the room so there rs; ocial Worker but Licensee ofessional #1 or Licensee					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED			
			MHL036-336	B. WING		09	09/29/2020	
		ROVIDER OR SUPPLIER	4460 HL	ADDRESS, CITY, S INTINGTON DR NIA, NC 28056				
	12	CUMBIADVOT		VIA, INC 20056				
PRE TA	FIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
\	/ 364	Continued From page	e 101	V 364				
				1				
		during the calls.						
		Social Worker reveal -Would have facetime #1; -Former Client #1 of staff involvement b "popping into the root staff were in close pro Interview on 9/3/20 w revealed: -Did not have privacy calls; -Staff listened to "They (staff) were b Interview on 8/19/20 w DSS Social Worker re -Staff almost always s	docial Services (DSS) ed: ee calls with Former Client would speak independent but staff would always keep m" and it was obvious the eximity. with Former Client #3 during telephone to all telephone calls; - to being nosey"					
		to each other.						
		Interview on 8/25/20 v Adoption Recruiter re- -There was no privacy						
		the calls were always Former Client #1 could background; -Two to three times th by staff when staff wor #3 "Oh, we are not go	ed:  old call almost daily but on speaker phone and d be heard yelling in the e calls were terminated uld say to Former Client ing to allow that!"					
		Interview on 8/13/20 w revealed: -Calls with her mother	with Former Client #4 were monitored (due to a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	-	
FRESH N	EW START	4460 HU	INTINGTON DRIV	√E		
	-	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 364	Interview on 8/12/20 DSS Social Worker re-Would make calls to was at the summer da privacy on calls when Brighter Dayz (Licer fully private conversations and when [Former Client # Was informed by Lice policy was for all calls -The facility never put monitoring phone call -Could hear kids screathatefully during calls v Had a video chat with took place at the home #2/Executive Director was highly unusual.  Interview on 9/11/20 v Clients were allowed to 15 minutes with via speaker phone; -Clients were only alloon their personalized legal guardian.  Interview on 9/21/20 w revealed: -Clients were allowed to legal guardian approve -Phone calls were mon	worker were monitored as a area and listen.  with Former Client #4's evealed: Former Client #4 when she ay camp as there was no she was at the facility; -" usee) staff would not allow tions. The staff would listen would hang up the phone #4] said she was upset" - usee #2/Executive Director to be monitored; anything in writing about s; aming and staff speaking with Former Client #4; - Former Client #4 which e of Licensee s home and thought that  with Staff #5 revealed: - to make phone calls for staff monitoring all calls weed to call individuals	V 364			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		10000	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09,	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
FRESH N	EW START	4460 HU	INTINGTON DRI	VE		
			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 364	Interview on 9/11/20 Clients were allowed individuals on their lis by the legal guardian -Calls were monitored -Had clients place the and staff sat next to the calls.  Interview on 9/22/20 v #1/2 revealed: -The clients were allow but all calls needed to telephone on speaker  Interview on 9/25/20 v #1/Director/Qualified I Licensee #2/Executive-Denied the clients ha monitored by staff; -Denied clients were d calls on speaker phone -Former Client #4's ph mother needed to be in Was not "running a bor privacy on phone calls -Clients were allowed	with Staff #8 revealed: - to make phone calls to st of contacts approved ; d; e phone on speaker phone he clients and listened to  with Former Staff  wed to use the telephone be monitored with the phone.  with Licensee Professional #1 and e Director revealed: d their phone calls  irected to put all personal e; one calls with her biological nonitored per court order; - otcamp" with not allowing ; to use the phone when ls were based upon their	V 364			
V 366	27G .0603 Incident Re 10A NCAC 27G .0603 RESPONSE REQUIRE CATEGORY A AND B	INCIDENT EMENTS FOR	V 366			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
	MHL036-336	B. WING		09/29/2020	
PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
NEW START		UNTINGTON DE			
NEW START	GASTO	NIA, NC 28056			
(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
66 Continued From pa	ge 104	V 366	V 366		10/22/220
(a) Category A and and implement writ response to level I, shall require the pro (1) attending needs of individual (2) determinin (3) developing corrective measures specified timeframe (4) developing to prevent similar in specified timeframes (5) assigning responsible for improrrections and pre (6) adhering to set forth in G.S. 75, 42 CFR Parts 2 and 164; and (7) maintaining Subparagraphs (a) (6) In addition to the Paragraph (a) of this shall address incider regulations in 42 CF (c) In addition to the Paragraph (a) of this providers, excluding develop and implem governing their responsance or while the billable service or while the billable service or while the provider to responsance (1) immediated by:	B providers shall develop en policies governing their II or III incidents. The policies vider to respond by: to the health and safety involved in the incident; go the cause of the incident; and implementing according to provider in not to exceed 45 days; and implementing measures cidents according to provider not to exceed 45 days; and implementing measures cidents according to provider not to exceed 45 days; cerson(s) to be ementation of the ventive measures; confidentiality requirements article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and a 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 onse to a level III incident provider is delivering a file the client is on the The policies shall require and by: A securing the client record	V 366	The agency will comply with all required 10A NCAC 27g .0603 including:  a. Ensuring that all Level II and I incidents are reported to DHS LME/MCO as required by the NC DHHS Incident Reporting (IRIS) within the IRIS and 10A 27g .0604 stipulated timeframe b. The agency will keep all incider reports on file for inspection for governmental authorities.  c. New hires and returning staff were trained in incident reporting phire/return and annually thereat The agency will contract with a Certified Forensic Healthcare Auditor to conduct quarterly self-audits to ensure this standard including cross walking Level I,II, & progress notes to incident reports.  When the Certified Forensic Health Carcontract expires a qualified agency staff assume the duties of monitoring compliatis POC. The Certified Forensic Health Auditor will train his replacement in standard audit practices.	II R and the prevailing System NCAC es. ent r will be prior to after. at least dard is III e Auditor will ance with h Care	

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/V2\ MULTIDLE	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		TE SURVEY MPLETED
		MHL036-336	B. WING			
Mark Control of the C		WITE030-330			09	0/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA			
FRESH N	EW START	4460 HL	INTINGTON DRIV	E		
	1	GASTO	NIA, 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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From page	e 105	V 366			
	(C) certifying the copy's completeness; and (D) transferring the copy to an					
	(D) transferring	the copy to an				
	internal review team;					
		a meeting of an internal hours of the incident. The				
	internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or					
	with direct profession	al oversight of the client's				
	services at the time of	the incident. The internal				
	services at the time of the incident. The internal review team shall complete all of the activities as					
	follows:	ipiete all of the activities as				
		copy of the client record to				
		nd causes of the incident				
		dations for minimizing the				
	occurrence of future in					
		r information needed;				
		n preliminary findings of fact				
	within five working day	ys of the incident. The				
		fact shall be sent to the				
		ent area the provider is				
		E where the client resides,				
	if different; and					
		written report signed by				
		months of the incident.				
	The final report shall be					
	whose catchment area	the provider is located				
	and to the LME where					
		ten report shall address				
		the internal review team,				
		documents pertinent to the				
		te recommendations for				
1	minimizing the occurre	nce of future incidents. If				
	all documents needed					
		nonths of the incident, the				
		ider an extension of up to				
	three months to submit					
		notifying the following:				
(	<ul><li>(A) the LME resp</li></ul>	consible for the catchment				

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
		MHL036-336	B. WING		09/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT		
FRESH N	EW START		JNTINGTON DRIVI NIA, NC 28056	E	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	ECTION
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLET
V 366	to Rule .0604; (B) the LME whif different; (C) the provider for maintaining and utreatment plan, if differentiation of the Departm (E) the client's leapplicable; and	ices are provided pursuant ere the client resides, agency with responsibility pdating the client's erent from the reporting	V 366		
	failed to ensure all inci- outlined in their policy a findings are:  Review on 8/11/20, 8/ Former Client #1's rec- Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disrup Disorder and Attention Disorder; -11 years old; -Discharge Summary c #1/Director/Qualified Pr 8/6/20 revealed difficult boundaries and person poor hygiene, and incid	d record review, the facility dents were reported as and procedure. The  12/20 and 8/18/20 of cord revealed:  otive Mood Dysregulation Deficit Hyperactivity  completed by the Licensee refessional #1 dated			

Division of Health Service Regulation

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
FRESH	IEW START	4460 HU	JNTINGTON DRIV	'E			
		GASTO	NIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
	Former Client #1 may a summer day camp intercourse in the pay property destruction physical aggression concerns were report behaviors of being upersulting in property defiance at least 4 to Review on 8/11/20, 8 Former Client #2's readmitted 7/10/20; -Discharged 8/7/20; -Discharged 8/7/20; -Diagnosed with Postand Attention Deficit -9 years old.  Review on 8/11/20, 8 Former Client #3's readmitted 6/12/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20; -Diagnosed with Atter Disorder, Post Traum Oppositional Defiant 13 years old; -Comprehensive Cliniaddendum completed Professional/Qualified 8/17/20 revealed: " boundaries and she to inappropriately often rehugging without permander Plan dated	ide 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 hable to control her impulses destruction, disrespect, and 5 times per week.  8/12/20 and 8/18/20 of ecord revealed:  12/20 and 8/18/20 of ecord revealed:  12/20 and 8/18/20 of cord revealed:  12/20 and 8/18/20 of cord revealed:  12/20 and 8/18/20 of cord revealed:  13/2/20 and 8/18/20 of cord revealed:  14/2/20 and 8/18/20 of cord revealed:  15/2/20 and 8/18/20 of cord revealed:  16/2/20 and 8/18/20 of cord revealed:  17/2/20 and 8/18/20 of cord revealed:  18/2/20 and 8/18/20 of cord revealed:  18/2/20 and 8/18/20 of cord revealed:  18/2/20 and 8/18/20 of cord revealed:	V 366	DEFICIENCY)			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E. ZIP CODE		
EDECUM	EW STADT		JNTINGTON DRIV			
FRESHIN	EW START	GASTO	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 366	appropriate boundari of staff and peers"  Review on 8/11/20, 8. Former Client #4's re -Admitted 4/24/20; -Discharged 8/6/20; -Discharged 8/6/20; -Diagnosed with Opporand Unspecified Traur-13 years old; -CCA Addendum con Professional/Qualified 8/1/20 revealed: clien intimacy, sexual abus sexually inappropriate Client #4] makes sexu displays sexual gestu physically and verball and peers at group he bullies younger peers constantly lies on staft to be sent home;" -Discharge Summary #1/Director/Qualified 18/6/20 revealed steali struggling with telling by pushing a peer off assault allegation; -Treatment Plan updat Client #4 manifested sfactual and continues factual and continues factual and continues factual and continues factual and threw them in the Requests to the Licen Professional #1 and L Director for all inciden 8/10/20 at approximate	es and the personal space  /12/20 and 8/18/20 of cord revealed:  positional Defiant Disorder ma;  pleted by the Licensed d Professional #2 dated t has difficulty with sexual perape, and displays behaviors and "[Former pual comments to peers and pres[Former Client #4] is y aggressive towards staff ome[Former Client #4] in the group homeShe if and peers in her attempt  completed by Licensee Professional #1 dated ng peers' clothing, the truth, physical assault the couch, and a sexual  see 8/6/20 revealed Former everal stories that are not to be untruthful, physically couch, and took another es and ripped the pictures ne garbage.  see #1/Director/Qualified	V 366			

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Division of Health Service Regulation

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	A	
FRESHN	EW START	4460 HL	INTINGTON DRIV	E		
		GASTO	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Report from 7/1/20Only one incident re Former Client #3; -No incident reports of Former Clients #1, #2  Requests to the Licer Professional #2 and I Director for the Incide made on 9/10/20 at 1 correspondence. Licer Professional #1 sent request.  Review on 9/10/20 of sent by Licensee #1/E Professional #2 revea - " In regard to your information (including we can provide when week. It is my underst #2/Executive Director) several times during the determine what you neverything without delabe a delay now being town. I hope you under Review on 9/15/20 of by the Licensee #9/14/20 at 8:12pm review -"I reached out to you sinform you that we will afternoon in order go/grequested (including Intervals).	of the facility's Incident 8/7/20 revealed: port submitted on were submitted for 2, #4, and #5.  Insee #1/Director/Qualified Licensee #2/Executive ent Reporting Policy was 2:31pm via email ensee #1/Director/Qualified an email in response to the the email correspondence Director/Qualified an email for the other Incident Reporting Policy), we return to Charlotte next anding that [Licensee   has reached out to you his investigation in order to eeded so you would have ay. Unfortunately there will that both of us are out of erstand."  The memail correspondence sent #2/Executive Director on realed: several times today to return to work later this get you the information you ecident Reporting Policy). I of contacted [Division of	V 366			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY IPLETED
		MHL036-336 B. WING			09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE ZIP CODE		20,2020
			UNTINGTON DRIV			
FRESH N	EW START		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V/ 266	Cantinual Fusion	- 440				
V 366	Continued From page	e 110	V 366			
	Branch Manager], in order to get clarification ondocuments requestedplease see the attached"  Review on 9/18/20 of the DHSR's surveyor's telephone upon return of the DHSR surveyor from being off from 9/15/20 - 9/17/20 revealed two calls from the Licensee #2/Executive Director were received on 9/14/20. One call was received at 2:02pm with no voicemail message being left and one call was received on 3:33pm with a request for a return call.  Review on 9/18/20 of the facility's undated Incident Reporting Policy revealed:					
	-"Any incidentregar					
		oproved incident Report				
		our hours of the incident				
		ned as any event which the routine operation of				
	the facility or the routi					
	Interviews on 9/2/20 a					
	Former Staff #12 reve					
	Clients from the facility	and Sister Facility A; -				
	often intermingled and					
		ast shift at Sister Facility A				
	she was working alone	e. She was asked to take				
		Former Client #2 to pick				
	up Former Clients #A1					
	from camp. After pickin	ng up the clients from  n the van which involved all				
		er Staff #12 was driving.				
		d for assistance, but none				
		Former Staff #12 did the				
	best she could to maint					
		ormer Staff #12 received a				
	phone call from License	ee #1/Director/Qualified				
	Professional #1 and Lic	censee #2/Executive				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		09/29/2020	
NAME OF PE	ROVIDER OR SUPPLIER	4460 HU	ADDRESS, CITY, S JNTINGTON DI NIA, NC 28056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B		3E	(X5) COMPLETE DATE
V 366 V 367	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment regardi incident reports.  This deficiency is cross NCAC 27G .1701 Scot A1 rule violation.	they were on a recorded ating Former Staff #12. with Licensee Professional #1 and e Director revealed: ng the lack of ss referenced into 10A	V 366	1/ 207		
	10A NCAC 27G .0604 REPORTING REQUIT CATEGORY A AND E (a) Category A and B level II incidents, exceduring the provision of the consumer is on th level III incidents and the clients to whom th service within 90 days LME responsible for th services are provided becoming aware of the be submitted on a form Secretary. The report mail, in person, facsim means. The report shall information: (1) reporting providentification informatio (2) client identific (3) type of incide (4) description of	REMENTS FOR B PROVIDERS providers shall report all sept deaths, that occur of billable services or while se providers premises or level II deaths involving se provider rendered any perior to the incident to the see catchment area where within 72 hours of se incident. The report shall an provided by the may be submitted via solice or encrypted electronic sell include the following vider contact and con; seation information; ant;		V 367 Cross reference to response t 366	o V	10/22/220

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Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
	404 LONG	MHL036-336	B. WING		09/29/2020	
	ROVIDER OR SUPPLIER	4460 HUNT	PRESS, CITY, ST FINGTON DRI A, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	or responding. (b) Category A and B missing or incomplet shall submit an updat report recipients by the day whenever: (1) the provider information provided erroneous, misleading (2) the provider required on the incide previously unavailable (c) Category A and B pupon request by the Lobtained regarding the (1) hospital recoconfidential informatio (2) reports by (3) the provided (d) Category A and B pof all level III incident in Mental Health, Develop Substance Abuse Sembecoming aware of the providers shall send a incidents involving a cof Health Service Regulation of Health Service Regulation of Health Service Regulation of the provider immediately, as required and 10A NCAC 27E .01 (e) Category A and B poreport quarterly to the Loatchment area where	providers shall explain any e information. The provider ted report to all required ne end of the next business has reason to believe that in the report may be gor otherwise unreliable; or obtains information nt form that was e. providers shall submit, ME, other information e incident, including: or other authorities; and or's response to the incident. Providers shall send a copy eports to the Division of prenental Disabilities and vices within 72 hours of e incident. Category A copy of all level III elient death to the Division or shall report the death ed by 10A NCAC 26C .0300 (104(e)(18)). roviders shall send aME responsible for the services are provided. The ed on a form provided by	V 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 3:		E SURVEY MPLETED	
			MHL036-336	B. WING		09	/29/2020	
	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
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l		CLIMMADY OF		A, NC 28056				
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	V 367	include summary infor (1) medication of definition of a level II (2) restrictive int the definition of a leve (3) searches of a (4) seizures of a the possession of a cl (5) the total num incidents that occurre (6) a statement if been no reportable incidents have occurre meet any of the criteria	errors that do not meet the or level III incident; erventions that do not meet I II or level III incident; client or his living area; client property or property in lient; ober of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that a as set forth in Paragraphs and Subparagraphs (1)	V 367				
		interview and record report all Level III incide management entity) recatchment area where within 72 hours of bed incident. The findings a	services are provided oming aware of the are:					
		Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #1's record revealed: -Admitted 12/27/19; -Discharged 8/6/20; -Diagnosed with Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder; -11 years old.						

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
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V 367	Continued From page	114	V 367			
	and Attention Deficit F -9 years old. Review on 8/11/20, 8/ Former Client #3's rec Admitted 6/12/20; -Discharged 8/4/20;	Traumatic Stress Disorder Hyperactivity Disorder;  12/20 and 8/18/20 of ford revealed: -  tion Deficit Hyperactivity thic Stress Disorder,				
	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.					
	On 7/31/20, 8/1/20, and Department of Social S	rofessional #1 revealed: - d 8/3/20, the local Services was investigating abuse involving Former #4. The allegations limited to, staff forcibly #1 and scrubbing her xual assault of Former ient #4, and Former				
	Review on 8/25/20 of th Response Improvemen	e North Carolina Incident t System (NC IRIS) for				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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V 367	Continued From page	e 115	V 367			
	period 7/1/20 - 8/25/20 revealed: -Incident report submitted on 8/9/20 regarding an incident on 8/3/20 for a "consumer allegation" made by Former Client #1. The incident report did not mention the nature of the allegation other than Former Client #1 reported she felt threatened by a local Department of Social Services Social Worker who was investigating the facility; -Incident report submitted on 8/4/20 regarding an incident on 8/3/20 for Former Client #2 alleging she was the victim of inappropriate touching by Former Client #4. There was no incident report completed on Former Client #4 even though she was involved in the incidentIncident report submitted on 7/22/20 regarding an incident on 7/21/20 for Former Client #1 when she ran away and was missing for 45 minutes. Local law enforcement was involvedSearched website by county, facility name, licensee name, and each client name. No other incident reports were located.					
	Interview on 9/25/20 v #1/Director/Qualified I Licensee #2/Executive -No comment regardir incident reports.	Professional #1 and e Director revealed:				
	This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation.					
V 513	27E .0101 Client Righ Alternative	ts - Least Restictive	V 513			
	10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports					

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V 513 Continued From page 116 V 513 V 513	0/22/220	
that promote a safe and respectful environment. These include:  (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:  (1) using the least restrictive and most appropriate settings and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:  (1) using the least restrictive and most appropriate settings and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the client/sequity exponsible person and staff. (b) The use of a restrictive intervention procedure designed to restrictive intervention. These include:  (1) using the least restrictive and most appropriate settings and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the client/sequity exponsible person and staff. (b) The use of a restrictive intervention procedure designed to restrictive intervention procedure designed to result and staff. (b) The use of a restrictive intervention procedure designed to result and staff. (b) The use of a restrictive intervention procedure designed to result and staff. (b) The use of a rest		

Division of Health Service Regulation

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	#2's record revealed: -Admitted 7/10/20; -Discharged 8/7/20; -Diagnosed with Post and Attention Deficit H-9 years old.  Review on 8/11/20 an #3's record revealed: -Admitted 6/12/20; -Discharged 8/4/20; -Discharged 8/4/20; -Discharged 8/4/20; -Diagnosed with Atten Disorder, Post Trauma Oppositional Defiant D-13 years old.  Review on 8/11/20 an #4's record revealed: -Admitted 4/24/20; -Discharged 8/6/20; -Diagnosed with Oppo and Unspecified Traur-13 years old.  Review on 8/11/20 and #5's record revealed: -Admitted 8/5/20; -Diagnosed with Post Disruptive Mood Dysre Unspecified Trauma; -10 years old.  Interview on 9/3/20 wit revealed: -"One day [Staff #8] ghands on my throat but was in the van at [Siste remember who was drivered was dri	Traumatic Stress Disorder Hyperactivity Disorder;  Id 8/12/20 of Former Client  Intion Deficit Hyperactivity atic Stress Disorder, Disorder, Depression;  Id 8/12/20 of Former Client  Institutional Defiant Disorder ma;  Id 8/12/20 of Former Client  Irraumatic Stress Disorder, and  In Former Client #3  Igot really mad and put her did not really choke me. In Facility A]Cannot	V 513	DEFICIENCY		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG:		(X3) DATE SURVEY COMPLETED	
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	V 513	Continued From page	118	V 513				
		fatstinkyp***y" and said Former Client #3"could not stop running her mouth"  Interview on 8/19/20 with Former Client #3's Department of Social Services Social Worker revealed: -Upon arrival at the facility to pick up Former Client #3 on 8/4/20, Former Client #3 was in the presence of the same staff member who had allegedly choked her.  Interview on 8/13/20 with Former Client #4 revealed: -Staff #8 put her hands around Former Client #3's throat and tried to choke her; -The incident occurred on the driveway of Sister Facility A; -Staff #8 and Former Client #3 were cursing at each other; -Former Client #3 later denied the incident because she liked Staff #8; -Staff #8 called Former Client #3 "a b***hglyfat" -Staff #9 called a local DSS worker a "b***h;" -Licensee #2/Executive Director, Staff #5, Staff #8, and Former Staff #12 had all cursed at Former Client #4; -Former Clients were not allowed out of their bedrooms until 10am.  Interview on 8/12/20 with Former Client #4's DSS Social Worker revealed: -Could hear kids screaming and staff speaking hatefully during calls with Former Client #4;  Interview on 8/25/20 with Former Client #1. They would pull her shirt and drag her to her room. Former Client #1"really didn't do nothingthey						

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED		
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	room; -"We had to sit in our Interview on 9/11/20 w Denied witnessing stafformer clients; -Denied witnessing stafformer clients.  Interview on 9/11/20 w Denied putting her ham #3's neck.  Interview on 9/22/20 w revealed:	intlythey put her in her bedrooms all the time"  with Staff #5 revealed: - if put their hands on any  iff curse at any  ith Staff #8 revealed: - ids around Former Client  ith Former Staff #12  iff #8 choke Former Client  former clients; iff curse at any former  th Licensee rofessional #1 and Director revealed:  referenced into 10A	V 513				
1.00	27E .0107 Client Rights Int.	- Training on Alt to Rest.	V 536				
	10A NCAC 27E .0107 ALTERNATIVES TO REINTERVENTIONS (a) Facilities shall implenoractices that emphasize	nent policies and					

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE COM	SURVEY PLETED
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	(f) Content of the train provider wishes to employ the Division of MH// Paragraph (g) of this F(g) Staff shall demons following core areas: (1) knowledge a people being served; (2) recognizing a human behavior; (3) recognizing the training and external stressors with disabilities; (4) strategies for relationships with personal providers to the providers of the	ploy must be approved DD/SAS pursuant to Rule. Strate competence in the and understanding of the and interpreting the effect of internal that may affect people building positive		Auditor will train his replacement in stan and audit practices.	dards	

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V 536	Continued From page organizational factors disabilities;  (6) recognizing assisting in the persor making decisions about (7) skills in asset for escalating behavior (8) communication and de-escalating pote and (9) positive behaviors which (providing means for pachoose activities which replace behaviors which (h) Service providers and the escalation of initial at least three years.  (1) Documentation (1) Documentation (2) The Division review/request this documentation (2) The Division review/request this documentation (3) The training stessing in an instructor (3)	that may affect people with the importance of and a's involvement in ut their life; essing individual risk r; on strategies for defusing intially dangerous behavior; avioral supports eople with disabilities to a directly oppose or the are unsafe). In and refresher training for on shall include: ated in the training and the interest they attended; and ame; ion of MH/DD/SAS cumentation at any time. In demonstrate competence etting in a training program ducing and eliminating the eventions. I demonstrate a passing grade on craining program.	may	V 536		NOT NATE	
	objectives, measurable	testing (written and by ) on those objectives and					

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
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	(4) The content the service provider p approved by the Divis pursuant to Subparag (5) Acceptable i shall include but are not (A) understandi (B) methods for the course; (C) methods for performance; and (D) documentati (6) Trainers sha experience teaching a preventing, reducing a restrictive interventions positive review by the (7) Trainers sha aimed at preventing, reneed for restrictive interventions positive review by the (7) Trainers sha aimed at preventing, reneed for restrictive interventions of the course of t	of the instructor training ans to employ shall be ion of MH/DD/SAS raph (i)(5) of this Rule. Instructor training programs of limited to presentation of: Ing the adult learner; teaching content of evaluating trainee  on procedures. If have coached training program aimed at ind eliminating the need for sat least one time, with coach. If teach a training program educing and eliminating the erventions at least once  I complete a refresher st every two years. In all maintain and refresher instructor expers. In the training and the interest attended; and in of MH/DD/SAS may documentation any time. If meet all preparation er.  Il teach at least three times	V 536			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
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V 536	train-the-trainer instr	pletion of coaching or	V 536			
	facility failed to ensural alternatives to restrict 1 of 10 audited staff in findings are:  Attempted review on #6's records was unswere made available the staff records were #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	and record review, the re staff were trained in tive interventions affecting members (Staff #6). The  9/4/20 and 9/8/20 of Staff uccessful as no records for review. Requests for e sent to Licensee Professional #1 and the Director on 9/4/20 at 18 to be sent via fax and 184pm for the records to be encrypted email.  at 12:36pm with Staff the interview because the rother job; ayz (Licensee/Sister)				
	#6 was unsuccessful. the mailbox was full. A	11/20 at 2:10pm with Staff There was no answer and text message was sent to ch was read at 2:12pm. A				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
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V 536	series of text message the DHSR surveyor of informed she would be a linear surveyor of the series of the property of the prope	nes between Staff #6 and ontinued and Staff #6 was be contacted as needed.  with Licensee Professional #1 and	V 536		
	10A NCAC 27E .0108 SECLUSION, PHYSIC AND ISOLATION TIM (a)Seclusion, physical out may be employed of been trained and have in the proper use of an procedures. Facilities of authorized to employ a procedures are retrained competence at least ar (b)Prior to providing didisabilities whose trea includes restrictive inte service providers, employed procedures shall completed seclusion, physical resout and shall not use to the training is completed demonstrated. (c)A pre-requisite for ta demonstrating competed	CAL RESTRAINT E-OUT restraint and isolation time- only by staff who have demonstrated competence d alternatives to these shall ensure that staff and terminate these and have demonstrated annually. rect care to people with traint/habilitation plan erventions, staff including oloyees, students or ete training in the use of straint and isolation time- hese interventions until ed and competence is king this training is	V 537	V 537 Cross reference to response to V 536	10/22/220

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY MPLETED
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	the need for restrictive (d) The training shall be include measurable le measurable testing (wo of behavior) on those methods to determine course.  (e) Formal refresher try by each service provided annually).  (f) Content of the training provider plans to employ the Division of MH/DD. Paragraph (g) of this F (g) Acceptable training but are not limited to, provider shall be included in the use of restrictive in (2) guidelines or (understanding immineration and others);  (3) emphasis on the rights and dignity of (using concepts of least and incremental steps).  (4) strategies for of restrictive interventions which increases sment and monitor psychological well-bein use of restrictive intervention;  (6) prohibited providers shall be increased in the provider shall	e interventions. De competency-based, arning objectives, rritten and by observation objectives and measurable passing or failing the  aining must be completed der periodically (minimum  ling that the service oby must be approved by /SAS pursuant to Rule. In programs shall include, presentation of: formation on alternatives to terventions; for when to intervene ent danger to self  safety and respect for fall persons involved for restrictive interventions in an intervention); the safe implementation for interventions in an intervention of the physical and gof the client and the safe fout the duration of the  specular of the physical and gof the client and the safe fout the duration of the  specular of the physical and gof the client and the safe fout the duration of the  specular of the physical and gof the client and the safe fout the duration of the  specular of the physical and gof the client and the safe fout the duration of the  specular of the physical and gof the client and the safe fout the duration of the	V 537			

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	at least three years.  (1) Documenta (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this do time. (i) Instructor Qua Requirements: (1) Trainers sha by scoring 100% on te aimed at preventing, re need for restrictive inte (2) Trainers sha competence by scorin training program teach physical restraint and (3) Trainers sha competence by scorin training program teach physical restraint and (3) Trainers sha competence by scorin testing in an instructor (4) The training competency-based, inco objectives, measurable observation of behavior measurable methods to failing the course. (5) The content the service provider pla approved by the Division pursuant to Subparagr (6) Acceptable in programs shall include, presentation of: (A) understandin (B) methods for scourse;	tion shall include: pated in the training and the where they attended; and name. In of MH/DD/SAS may patementation at any palification and Training all demonstrate competence patentiating in a training program paducing and eliminating the perventions. In demonstrate graph 100% on testing in a paining the use of seclusion, patentiation time-out. In demonstrate graph apassing grade on patentiating program. In the second program is a seclusion of the instructor training program. In the second program is a second program in the second program. In the second program is a second program in the second program in the second program is a second program in the s	V 537			
1	(D) documentation	on procedures.				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE : A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRE	CTION	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	(7) Trainers sha annually and demons use of seclusion, phystime-out, as specified Rule. (8) Trainers sha in CPR. (9) Trainers sha in teaching the use of least two times with a coach. (10) Trainers sha inteaching the use of restrictive ir annually. (11) Trainers sha instructor training at least (k) Service providers sha coumentation of initial training for at least thre (1) Documentati (A) who participathe outcome (pass/fail) (B) when and who could be a compared this documentation of Coaches sha requirements as a train (2) Coaches sha times, the course which	all be retrained at least trate competence in the sical restraint and isolation in Paragraph (a) of this all be currently trained all have coached experience restrictive interventions at positive review by the all teach a program on atterventions at least once all complete a refresher ast every two years. The hall maintain all and refresher instructor be years. From shall include: a deted in the training and ame. From the hall preparation at any time. The second at least three is being coached. Ill demonstrate stion of coaching or tion. Ill be the same	V 537			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED	
		MHL036-336	B. WING		09	/29/2020	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT		03/	23/2020	
FRESH N	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 537	Continued From pag	ne 128	V 537				
	facility failed to ensur seclusion, physical re out affecting 1 of 10 a #6). The findings are:  Attempted review on #6's records was unswere made available the staff records were #1/Director/Qualified Licensee #2/Executiv 9:53am for the record again on 9/8/20 at 1:3 sent via secured and Interview on 9/11/20 #6 revealed:  -Not a good time for a she was working at he-"I start my Brighte Facility A) shift after s  Attempted interview 9/ #6 was unsuccessful. the mailbox was full. A the phone 2:11pm whi series of text message	and record review, the re staff were trained in restraint and isolation time-reducted staff members (Staff successful as no records for review. Requests for research to Licensee Professional #1 and re Director on 9/4/20 at restraint to be sent via fax and restraint to be sent via fax and restraint to be encrypted email.  There was no answer and record to the record to be recorded at 2:10pm with Staff record to the record to the record to be recorded at 2:12pm. A restraint and recorded at 2:12pm. A restraint and staff #6 and recorded at the record at 2:12pm. A restraint and recorded at 2:12pm. A recorded at 2:12pm.					

					,	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	
	01 0011112011011	DENTI ICATION NOMBEA.	A. BUILDIN	Ġ:	COMPLETED	
			4- 5-0-0-0-0-0			
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE ZIP CODE		
EDEOLL	EW 07.87		UNTINGTON DI			
FRESH N	EW START		NIA, NC 28056			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		1
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEFICIENCY)		
V 537	Continued From page	129	V 537			
	NCAC 27G .1701 Sco	pe (V293) for a Type A1				
	rule violation.	, , , , , , , , , , , , , , , , , , , ,				
V 541	27F .0104 Client Right	ts - Stor. & Protect of	V 541	V 541		
	Cloth/Poss					10/22/220
				The agency will make every e	ffort to	
	10A NCAC 27F .0104			protect each client's personal		
	PROTECTION OF CL POSSESSIONS	OTHING AND		clothing and possessions fron	theft.	
	Facility employees sha	all make every effort to		damage, destruction, loss, an		
	protect each client's pe			misplacement. This includes,		
		t, damage, destruction,		not limited to, assisting the clie	ent in	
	loss, and misplacemer	nt. This includes, but is not		developing and maintaining ar		
		e client in developing and		inventory of clothing and person		
	maintaining an invento	ry of clothing and personal				
	person desires.	nt or legally responsible		possessions if the client or leg	ally	1
	person desires.			responsible person desires.		
				Specifically, the agency will		
	This Rule is not met as			inventory all client possession	S	
		record review, the facility		upon admission and upon		
	failed to protect clients'	personal possessions		discharge. Any items that were	e lost	
	affecting 3 of 5 audited	former clients (Former		or discarded as well as any ne	w	
	Clients #1, #3, and #4).	The findings are:		items will be accounted for. Th	is will	
	Finding #1			be documented and kept in the	Э	
		8/12/20 of Former Client		record.		
	#1's record revealed:			N. SEASTANNING		
to the second se	-Admitted 12/27/19;			If an item is found after discha	rne	
- 1	-Discharged 8/6/20;			for example, a shirt found under		
		tive Mood Dysregulation		bed, the item will be delivered		
	Disorder and Attention Disorder;	Deficit Hyperactivity		mailed to the clients at the new		
	-11 years old.				v	
	yours old.			address within 48 hours.		
1	Interview on 8/14/20 wi	th Former Client #1				
1	revealed:					
-	-Was upset her electror	nic tablet was not returned				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY MPLETED
		MHL036-336	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		,20,2020
FRESHN	EW START		JNTINGTON DR	IVE		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	NIA, NC 28056	PROVIDER'S PLAN OF CORE		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
V 541	Continued From page		V 541			
	to her upon discharge	from the facility.				
	Interview on 9/3/20 wi Department of Social	Services (DSS)				
		d: till has not received her he facility despite requests.				
	Review on 9/4/20 of E from Former Client #1	mail Correspondence				
	dated 9/4/20 at 2:52pm Service Regulation Su	n to Division of Health				
	-Former Client #1's ele finally returned (29 day					
	Finding #2 Review on 8/11/20 and	d 8/12/20 of Former Client				
	#3's record revealed: -Admitted 6/12/20;					
	<ul><li>-Discharged 8/4/20;</li><li>-Diagnosed with Attent</li></ul>	ion Deficit Hyperactivity				
	Disorder, Post Trauma Oppositional Defiant D -13 years old.					
	Interview on 8/19/20 w DSS Social Worker rev					
	-Upon discharge, Form provided with her P-EE	BT (Pandemic Electron				
	the facility on 7/21/20 a	The card was pinned by after the facility had given harge for Former Client				
	#3; -Called Food Stam canceled the card and	ps Office and officially requested a new card				
	There was no activity of facility.	on the card from the				
	Finding #3 Review on 8/11/20 and	8/12/20 of Former Client				
;	#4's record revealed:				G.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The Samuel Comment	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			THE BOILDING.			PLETED
		MHL036-336	B. WING		09/	29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
FRESH N	EW START		UNTINGTON DRIV	E		
	CINAL SV		NIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 541	and Unspecified Tra- 13 years old;  Interview on 8/13/20 #4 revealed: -Had a cell phone w -Licensee #2/Execut A clothing voucher n #2/Executive Director Social Worker; -The clothing vouch or early July; -Former Client #4 wanever received the colling the cell phone and never returned by th  Interview on 9/18/2 DSS Social Worker -The cell phone and never returned by th  Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv Licensee #2/Executiv Client #4's DSS Soci Client #4 she could r was taken away and #4's biological mother -Licensee #2/Execut Former Client #4's cl threw it in the garbag This deficiency is cro	positional Defiant Disorder auma;  Di with Former Client  then she moved to the facility; tive Director took the phone; - made out to Licensee or was sent by her DSS  ther was sent in late June  as never taken shopping and lothing voucher money.  Di with Former Client #4's revealed: clothing money was the facility.  with Licensee Professional #1 and the Director revealed: The Director revealed Former and Worker told Former took keep the cell phone so it mailed to Former Client  ther; tive Director voided othing voucher and	V 541			

Division of Health Service Regulation