STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 4/16/21 as a result of the request by the licensees after the informal conference meeting held on 12/2/20. The complaint was substantiated (Intake #NC173231). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for	V 109		

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V 109	Continued From page 1 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on interview and record review, 1 of 2 audited qualified professionals (Licensee #1/Director/Qualified Professional #1) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 3/17/21 of Licensee #1/Director/Qualified Professional #1's record revealed: -Hire date of 2/1/18; -Was retrained in First Aid, Cardiopulmonary Resuscitation, Bloodborne Pathogens, Medication Administration, Seizure Management, Mental Health/Developmental Disabilities/Substance Abuse Services, Client Specific Trainings, Alternatives to Restrictive Intervention, Seclusion, Physical Restraint, and Isolation Time-Out, Orientation, Rights and Confidentiality, Population Served, Documentation, Crisis Planning and Management, Person Centered Planning, Health and Safety, Cultural Competency, Sexually	V 109		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 109	Continued From page 2	V 109		

Aggressive Youth, and Incident Response Improvement System during October, 2020.

Review on 4/1/21 of Licensee #1/Director/Qualified Professional #1's Job Description revealed:
-Job description signed by Licensee #1/Director/Qualified Professional #1 dated 2/1/18 revealed job responsibilities included " ...supervision of the associate professionals and para-professionals, oversight of emergencies, provision of direct psycho educational services to children or adolescents, participation in treatment planning meetings, coordination of each child or adolescent's treatment plan, provision of basic case management functions ..."

Review on 3/18/21 of the Statement of Deficiencies completed as a result of 9/29/20 Division of Health Service Regulation (DHSR) survey revealed:
-Licensee #1/Director/Qualified Professional #1 was cited for failure to demonstrate the knowledge, skills, and abilities required by the population served;
-Plan of Protection dated 9/29/20 written and signed by Licensee #1/Director/Qualified Professional #1 revealed: " ...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 by 10/18/20: technical knowledge; cultural awareness; analytical skills; decision-making; interpersonal skills; communication skills; and clinical skills ..."

Review on 3/18/21 of the Plan of Correction completed in response to the 9/29/20 DHSR survey with targeted correction completion date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 109	Continued From page 3 10/22/20 revealed: -" ...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. To ensure compliance with standards around ...person-centered planning the agency's Licensed Mental Health Professional will review and approve all ...person-centered plans prior to implementation. The plans will be reviewed for completeness and clinical appropriateness ..." Review on 2/17/21 of Client #1's record revealed: -Client #1's treatment plan dated 9/21/20 with most recent update 1/7/21 revealed no strategies for AWOL (absent without leave), self-harm attempts, or methods of ensuring supervision when away from the facility despite the client's history and job placement; -Client #1's February, 2021 MAR (medication administration record) included several blanks making it impossible to determine if medications were administered as ordered (Refer to 10A NCAC 271g .0209 Medication Requirements (V118) for specifics). Review on 2/17/21 of Client #2's record revealed: -Client #2's treatment plan dated 10/26/20 with most recent update 1/14/21 revealed no strategies for AWOL or self-harm attempts despite the client's history.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 109	Continued From page 4 Review on 2/17/21 of the facility's Incident Reports revealed: -There was no Level III incident report completed regarding the allegation of Former Staff #3 offering marijuana to Client #1 in January, 2021. Review on 2/17/21 of Former Staff #4's record revealed: -No state issued driver's license in the record. Interview on 2/17/21 with Client #1 revealed: -Had a job in November, 2020 at a local fast food restaurant and worked there for 4-5 days; -Staff did not visit her at work except for one time when they took her medications to the local fast food restaurant to administer the medications to her. Interview on 2/17/21 with Client #2 revealed: -Went AWOL from the group home one time and was missing for 3-4 hours; -Did not know where he was going when he went AWOL; -Had $100 from his Christmas money with him when he went AWOL so he could purchase a knife because he " ...wanted to gut myself ...;" -Was found by local law enforcement during the AWOL before he could harm himself and was taken to the hospital and admitted. Interview on 2/17/21 with Former Staff #4 revealed: -Did not have a valid driver's license; -Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director knew she did not have a valid driver's license; -Provided a state issued identification card when she was hired which was not a valid driver's license;	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 109	Continued From page 5 -Was instructed to drive Client #1 and Client #2 in the company vehicle by Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director despite that they knew she did not have a valid driver's license; -During surveys and investigations, Licensee #1/Director/Qualified Professional #1 would call and text staff and talk to them about getting their stories straight before speaking with surveyors and investigators; -Upon telling the truth about the facility to a Department of Social Services (DSS) staff member, stopped getting calls and texts from Licensee 1/Director/Qualified Professional #1. Interview on 2/17/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was responsible for developing the treatment plan goals and strategies. -Not sure why there are marks crossing out the first several days of medications administration on Client #1's February, 2021 MAR; -Would need to ask the House Manager regarding the lack of notation of medication administration for several days during the first week of February, 2021; -The House Manager was responsible for overseeing the MARs. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was responsible for developing treatment plan goals and strategies; -Former Staff #4 should have furnished a valid driver's license; -Will re-check her record and notify DHSR survey staff; -Was not aware a Level III incident report needed to be completed regarding allegations of abuse or neglect.	V 109		

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 109	Continued From page 6 No additional evidence regarding Former Staff #4 having a valid driver's license was provided for review after being requested during interviews on 3/31/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director. This deficiency constitutes a recited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills;	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 110	Continued From page 7 (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on interview and record review, 1 of 7 audited paraprofessionals (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 3/17/21 of Licensee #2/Executive Director's record revealed: -Hire date of 2/1/18. -Was retrained in First Aid, Cardiopulmonary Resuscitation, Bloodborne Pathogens, Medication Administration, Seizure Management, Mental Health/Developmental Disabilities/Substance Abuse Services, Client Specific Trainings, Rights and Confidentiality, Population Served, Crisis Planning and Management, Health and Safety, Plan of Correction, Documentation, Person Centered Planning, Cultural Competency, Security and Accessibility of Records, Sexually Aggressive Youth, and Incident Response Improvement System during October, 2020. Review on 4/1/21 of Licensee #2/Executive Director's Job Description revealed: -Job description signed by the Licensee	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 110	Continued From page 8 #2/Executive Director dated 2/3/18 revealed job responsibilities included " ...HR (human resources) records, client records, intake process, MARs (medication administration records) planning outing, filing reports, authorizations, communicate directly with MCO/LME (managed care organizations/local management entities), DSS (Department of Social Services), (DHSR (Division of Health Service Regulation), legal guardian, DJJ (Department of Juvenile Justice), etc. schedule trainings, oversee financial management, develop budgets, evaluate performance, handle conflict with staff and client, assist with discharge process, Etc.: performing different task that can vary by setting ..." Review on 3/18/21 of the Statement of Deficiencies completed as a result of 9/29/20 Division of Health Service Regulation (DHSR) survey revealed: -Licensee #2/Executive Director was cited for failure to demonstrate the knowledge, skills, and abilities required by the population served; -Plan of Protection dated 9/29/20 written and signed by Licensee #1/Director/Qualified Professional #1 revealed: " ...will comply with all requirements of 10A NCAC 27G .0204 including ensuring the competency of the para professionals. Specifically, newly hired and returning para professionals will receive training by a qualified trainer prior to starting work: technical knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills, and clinical skills ..." Review on 2/17/21 of Client #1's record revealed: -Client #1's treatment plan dated 9/21/20 with most recent update 1/7/21 revealed no strategies for AWOL (absent without leave), self-harm	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 110	Continued From page 9	V 110		

attempts, or methods of ensuring supervision when away from the facility despite the client's history and job placement;
-Client #1's February, 2021 MAR (medication administration record) included several blanks making it impossible to determine if medications were administered as ordered (Refer to 10A NCAC 271g .0209 Medication Requirements (V118) for specifics).

Review on 2/17/21 of Client #2's record revealed:
-Client #2's treatment plan dated 10/26/20 with most recent update 1/14/21 revealed no strategies for AWOL or self-harm attempts despite the client's history.

Review on 2/17/21 of the facility's Incident Reports revealed:
-There was no Level III incident report completed regarding the allegation of Former Staff #3 offering marijuana to Client #1 in January, 2021.

Review on 2/17/21 of Former Staff #4's record revealed:
-No state issued driver's license in the record.

Interview on 2/17/21 with Client #1 revealed:
-Had a job in November, 2020 at a local fast food restaurant and worked there for 4-5 days;
-Staff did not visit her at work except for one time when they took her medications to the local fast food restaurant to administer the medications to her.

Interview on 2/17/21 with Client #2 revealed:
-Went AWOL from the group home one time and was missing for 3-4 hours;
-Did not know where he was going when he went AWOL;
-Had $100 from his Christmas money with him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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
V 110	Continued From page 10	V 110		

when he went AWOL so he could purchase a knife because he " ...wanted to gut myself ...;"
-Was found by local law enforcement during the AWOL before he could harm himself and was taken to the hospital and admitted;
-Wanted to find employment but " ...[Licensee #2/Executive Director] said I would set myself up to fail due to lack of social skills ..."

Interview on 2/17/21 with Former Staff #4 revealed:
-Did not have a valid driver's license;
-Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director knew she did not have a valid driver's license;
-Provided a state issued identification card when she was hired which was not a valid driver's license;
-Was instructed to drive Client #1 and Client #2 in the company vehicle by Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director despite that they knew she did not have a valid driver's license;
-During surveys and investigations, Licensee #1/Director/Qualified Professional #1 would call and text staff and talk to them about getting their stories straight before speaking with surveyors and investigators;
-Upon telling the truth about the facility to a Department of Social Services (DSS) staff member, stopped getting calls and texts from Licensee #1/Director/Qualified Professional #1.

Interview on 3/31/21 with Licensee #2/Executive Director revealed:
-Responsible for " ...checking behind the house manager ...;"
-Licensee #1/Director/Qualified Professional #1 was responsible for developing the treatment plan goals and strategies;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 110	Continued From page 11 -When asked why Client #1's February, 2021 had a line through several days of medication administration in the beginning of the month responded " ...I don't know ...;" -Former Staff #4 had a valid driver's license; -Took a copy of all staff driver's licenses at hire; -Will re-check Former Staff #4's record and make sure there wasn't another page not sent to DHSR and will re-send it. Interview on 4/8/21 with Licensee #2/Executive Director revealed: -Did not report the allegation of Former Staff #3 offering marijuana to Client #1 through NC IRIS (North Carolina Incident Response Improvement System) because in the NC IRIS handbook it revealed that all allegations are to be reported to HCPR (Health Care Personnel Registry); -Licensee #2/Executive Director revealed she spoke with the LME (Local Management Entity) representative who handled IRIS and never discussed the HCPR information could be entered through IRIS. No additional evidence regarding Former Staff #4 having a valid driver's license was provided for review after being requested during interviews on 3/31/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director. This deficiency constitutes a recited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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
V 112	Continued From page 12 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement strategies to address the needs of the clients affecting 2 of 2 clients (Client #1 and Client #2). The findings are:	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 112	Continued From page 13 Review on 2/17/21 of Client #1's record revealed: -Admitted 10/26/20; -Diagnosed with Depressive Disorder, Trauma Stressor, Disruptive Mood Dysregulation Disorder; -16 years old; -History of repeated AWOL (absent without leave) with episodes lasting up to one month at a time, overdose, suicide attempts, cutting; -Job placed at a local fast food restaurant within one month of admission to the facility with no assessment to determine the ability to work unsupervised; -Treatment plan dated 9/21/20 with most recent update 1/7/21 revealed no strategies for AWOL, self-harm attempts, or methods of ensuring supervision when away from the facility despite the client's history and job placement; -Crisis plan notation revealed: "To be completed upon completion of admission quarantine process due to COVID-19 precautions/protocols;" -No crisis plan was made available for review. Review on 2/17/21 of Client #2's record revealed: -Admitted 10/24/20; -Diagnosed with Post-Traumatic Stress Disorder and Major Depressive Disorder; -14 years old; -History of AWOL, self-injurious behaviors and suicidal ideation; -Treatment plan dated 10/26/20 with most recent update 1/14/21 revealed no strategies for AWOL or self-harm attempts despite the client's history. Interview on 2/17/21 with Client #1 revealed: -Had a job at a local fast food restaurant in November, 2020 and worked there for 4-5 days before the facility staff took her out of work "because it was interfering with my treatment;" -Staff transported her to and from work;	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 112	Continued From page 14 -Staff did not visit her at work except for one time when they took her medications to the local fast food restaurant to administer the medications to her. Interview on 2/17/21 with Client #2 revealed: -Facility staff (unable to identify which staff) assisted him with filling out applications for employment to work at local fast food restaurants but " ...[Licensee #2/Executive Director] said I would set myself up to fail due to my lack of social skills ...;" -Went AWOL from the group home one time and was missing for 3-4 hours; -Did not know where he was going to when he went AWOL, but tried to find the day treatment center he attended; -Had $100 from his Christmas money with him when he went AWOL so that he could purchase a knife because he " ...wanted to gut myself ..." -Was found by local law enforcement during the AWOL before he could harm himself and was taken to the hospital and admitted. Interview on 2/24/21 with Staff #1 revealed: -Worked with Staff #2 the night Client #2 went AWOL; -Upon arriving on her shift the night Client #2 went AWOL, she found Client #2 had his clothes on and was pacing the floor which was unusual as Client #2 was always prepared for bed when she arrived at work; -About 20 minutes into her shift, Client #2 went to his bedroom and Staff #1 heard a loud noise; -Upon investigating what the noise was, saw Client #2 exiting the facility through his bedroom window; -Called local law enforcement who arrived and searched for Client #2; -Client #2 was missing for 3 to 3 ½ hours;	V 112		

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V 112	Continued From page 15 -Client #2 was located by local law enforcement and was taken to the hospital. Interview on 2/24/21 with Staff #2 revealed: -Worked the night Client #2 went AWOL; -Client #2 had gone to his room and closed the door; -Heard a loud thump and went to check on Client #2 but he had gone out the window; -Verbally prompted Client #2 to return but he did not respond; -Called local law enforcement. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was responsible for developing treatment plan goals and strategies. -Client #1 was " ...moody ..." and did not work long but only worked a few days; -Staff transported Client #1 to work and checked up on her at work; -Client #2 jumped out his window when he went AWOL. Local law enforcement was called and they were given a photograph of Client #2 and Client #2 was found a little while later. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Licensee #1/Director/Qualified Professional #1 was responsible for developing treatment plan goals and strategies; -Client #1 worked at a local fast food restaurant but did not want to work when scheduled; -Client #1 wanted to leave work after 30 minutes; -Client #1 needed help with independent living skills; -Staff drove Client #1 back and forth to work; -Client #1 did not stay at work long enough to be checked on by staff. She " ...worked maybe three days ..." for " ...1 to 1 ½ hours...;"	V 112		

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V 112	Continued From page 16 -Client #2 went AWOL. Staff heard a boom and he jumped out of his window when the staff went to check on him. Local law enforcement was called. Client #2 never said why he went AWOL. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director. This deficiency constitutes a recited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of	V 118		

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V 118	Continued From page 17 all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure medications were administered as ordered by the physician affecting 1 of 2 clients (Client #1). The findings are: Review on 2/17/21 and 3/16/21 of Client #1's record revealed: -Admitted 10/26/20; -Diagnosed with Depressive Disorder, Trauma Stressor, Disruptive Mood Dysregulation Disorder; -16 years old; -Physician's orders dated 2/3/21 for Prazosin HCl (used to treat nightmares and insomnia which can increase suicide risk) 2mg (milligram) 1 cap (capsule) daily and Abilify (used to treat mood disorders and depression) 5mg 2 tabs daily;	V 118		

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V 118	Continued From page 18 -Physician's orders dated 10/26/20 for Mirtazapine (used to treat depression and restore the balance of neurotransmitters) 15mg 1 tab (tablet) daily; -Physician's orders dated 12/9/20 for Zoloft (used to treat depression, panic attacks and anxiety) 25mg 1 tab daily; -February, 2021 MAR revealed: -no documentation of administration of Prazosin 2/1/21 through 2/3/21; -no documentation of administration of Mirtazapine 2/1/21 through 2/5/21; -no documentation of administration of Zoloft 2/1/21 through 2/6/21; -no documentation of administration of Abilify 2/1/21 through 2/4/21. Interview on 3/9/21 with Staff #2 revealed: -Administered medications in the mornings; -Did not have any issues with not having all the medications listed on the client MARs; -Must check three times before administering medication - check the name of the prescription, how many milligrams, how often the medication is administered, name of the client, and match the MAR to the pill pack. Interview on 3/8/21 with the Associate Professional revealed: -Administered medications to the clients; -Unsure about any problems with the MARs; -The House Manager was responsible for the MARs. Interview on 3/22/21 with the House Manager revealed: -Administered medications to the clients; -All medications were listed on the MARs; -Did not know what happened to the February, 2021 MARs to have lines through the first few	V 118		

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V 118	Continued From page 19 days of the month; -" ...I messed up the MARs. I am no longer over the MARs. [Licensee #2/Executive Director] is over the MARs. Not even sure what I did ...;" -Was unable to identify if the medications were administered properly during the first few days of February, 2021. Interview on 2/17/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Not sure why there are marks crossing out the first several days of medication administration on Client #1's February, 2021 MAR; -Would need to ask the House Manager regarding the lack of notation of medication administration for several days of the first week of February, 2021; -The House Manager was responsible for overseeing the MARs. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was possible he administered medications at the facility since 2/1/21 but was not sure and he would need to check the MARs to determine if he did administer medications; -The medication administration protocol to follow to administer medications was to retrieve the medications from a double locked cabinet, wear gloves, get the pharmacy pre-packaged medication packs, peel back the plastic label, hand the plastic receptacle to the clients for the clients to take the medications; -It was "human error" that Client #1's medications were not signed as administered during the first week of February, 2021; -The House Manager was responsible for ensuring the medications were signed as administered but now the Licensee #2/Executive Director is handling oversight of the MARs;	V 118		

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V 118	Continued From page 20 -Believed Client #1 received all of her medications as ordered by the physician in February, 2021 because the medications arrive from the pharmacy pre-packaged and the pharmacy fills the orders according to the physician's orders which essentially "took the thought out of it (medication administration)" when they made the decision to pre-package the medications with the pharmacy. Plus, the Licensee #2/Executive Director completes a pill count. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Administered medications at the facility since 2/1/21; -The medication administration protocol to follow to administer medications was to wear gloves, take the plastic container the medications arrive from the pharmacy in and peel the back label off, put the medications in the client's mouth, drink water, swallow and allow the staff to check the client's mouth; -When asked why Client #1 medication were not signed as administered on the February, 2021 MAR she revealed " ...I don't know ...;" -Believed Client #1 received all of her medications as ordered by the physician in February, 2021 because she was able to check the back of the label of each individual plastic blister pre-packaged by the pharmacy and check the pill count against the top of the package. These checks were completed weekly and were random. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information	V 118		

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V 118	Continued From page 21 to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director during the exit meeting. Observation on 2/17/21 at approximately 10:25am of Client #1's medications revealed: -Prazosin HCl 2mg, Abilify 5mg, Mirtazapine 15mg, and Zoloft 25mg dispensed 2/3/21. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a recited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 118		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have	V 293		

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V 293	Continued From page 22 co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide	V 293		

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V 293	Continued From page 23	V 293		

supervision and structure of daily living, minimize the occurrence of behaviors related to functional deficits, ensure safety and deescalate out of control behaviors, assist in the acquisition of adaptive functioning and gaining the skills needed to step-down to a less intensive treatment setting affecting 2 of 2 clients (Client #1 and Client #2). The findings are:

CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109)
Based on interview and record review, 1 of 2 audited qualified professionals (Licensee #1/Director/Qualified Professional #1) failed to demonstrate the knowledge, skills, and abilities required by the population served.

CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110)
Based on interview and record review, 1 of 7 audited paraprofessionals (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served.

CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112)
Based on interview and record review, the facility failed to develop and implement strategies to address the needs of the clients affecting 2 of 2 clients (Client #1 and Client #2).

CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V118)
Based on interview, record review, and observation, the facility failed to ensure medications were administered as ordered by the

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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 24 physician affecting 1 of 2 clients (Client #1). CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) Based on interview and record review, the facility failed to report all Level III incidents to the LME (local management entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. CROSS REFERENCE: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536) Based on interview and record review, the facility failed to ensure staff were trained in alternatives to restrictive interventions affecting 1 of 10 audited staff members (Licensee #2/Executive Director). CROSS REFERENCE: 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537) Based on interview and record review, the facility failed to ensure staff were trained in seclusion, physical restraint, and isolation time-out affecting 1 of 10 audited staff members (Licensee #2/Executive Director). Finding #1 Review on 2/17/21 of Former Staff #4's record revealed: -Hired 11/3/20; -Terminated 1/3/21; -Employed as direct care staff; -State issued identification card in the record; -No state issued driver's license in the record. Interview on 2/17/21 with Client #1 revealed:	V 293		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 293	Continued From page 25 -Former Staff #4 used her cell phone while driving; -Former Staff #4 was told she was not allowed to drive anymore because she put Client #1 and Client #2 in danger; -Was in the van while Former Staff #4 drove; -Former Staff #4 took Client #1 to her house and Client #1 went inside the house and was in the downstairs; -Former Staff #3 took Client #1 to her house. Former Staff #3 went into the house but Client #1 was left outside of the house. Interview on 2/17/21 with Client #2 revealed: -Former Staff #4 was a "terrible driver ...can't drive at all ...;" -Former Staff #4 took Client #2 " ...to her house ..." and the "park with her friends smoking ...;" -Went to Former Staff #4's house a few times and discussed seeing her bedroom and a hookah. Multiple attempted interviews with Former Staff #3 were unsuccessful. Phone messages were left for Former Staff #3 requesting a call back on 2/23/21, 2/24/21, 2/25/21, and 3/22/21. Additionally, a text message was sent on 3/22/21 but was marked at "Not Delivered!" Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Former Staff #4 should have furnished a valid driver's license; -Will re-check her record and notify Division of Health Service Regulation (DHSR) survey staff tomorrow. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Former Staff #4 had a valid driver's license; -Took a copy of all staff driver's licenses at hire;	V 293		

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V 293	Continued From page 26 -All staff must provide a copy of a driver's license at hire; -Will re-check her record and make sure there wasn't another page not sent to DHSR and will send it. No additional evidence regarding Former Staff #4 having a valid driver's license was provided for review after being requested during interviews on 3/31/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director during the exit meeting. This deficiency constitutes a recited deficiency. Review on 4/8/21 of the first Plan of Protection written by Licensee #1/Director/Qualified Professional #1 dated 4/8/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Brighter Dayz (Licensee, Brighter Dayz, LLC) will: V109: Brighter Dayz 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 within the 23 days about: 1. technical knowledge; 2. cultural awareness; 3. analytical skills; 4. decision-making;	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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
V 293	Continued From page 27 5. interpersonal skills; 6. communication skills; and 7. clinical skills. V110: Brighter Dayz will comply with all requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, the ED (Executive Director) will receive training by a qualified trainer within the 30 days of hire or return to work: 8. technical knowledge; 9. cultural awareness; 10. analytical skills; 11. decision-making; 12. interpersonal skills; 13. communication skills; and 14. clinical skills. Specifically QP/ED (Qualified Professional/Executive Director) will ensure that all DC (direct care) staff provide a copy of a Valid Drivers License (unexpired) as part of onboarding process. QP will also ensure that as part of HCPR (Health Care Personnel Registry) notification, Incident report is filed in IRIS (Incident Reporting Improvement System) involving allegations against staff. V112: Brighter Dayz will comply with all requirements of 10A NCAC 27G .0205 including: a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented b. Specifically, Clients will not be able to obtain employment unless staff is present for the entire workshift. c. Specifically, QP will ensure that interventions for historical behavior (AWOL(absent without leave)/ELOPEMENT) are inserted in the support/intervention section of the PCP (person centered plan). QP will document prior histories	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 293	Continued From page 28 and have a meeting which will serve to establish which histories are still a concern, and develop strategies based on those concerns. ED will also attend retraining in core areas identified. V118: Brighter Dayz will comply with all requirements of 10A NCAC 271g .0209 including ensuring all direct care staff have documented training by qualified trainer in the following topics: a. Medication dispensing: Medication packaging and labeling b. Medication administration c. Medication disposal d. Medication Storage e. Medication review f. Medication education g. Medication errors Specifically, the staff who was completing MAR (medication administration record) is no longer doing so. This responsibility has been and will be shifted back to the Executive Director. V367: : Brighter Dayz will comply with all requirements of 10A NCAC 27g .0603/.0604 including: d. Ensuring that all Level II and III incidents are reported to DHSR (Division of Health Service Regulation) and the LME/MCO (local management entity/managed care organization) as required by the prevailing NC DHHS (North Carolina Department of Health and Human Services) Incident Reporting System (IRIS) within the IRIS and 10A NCAC 27g .0604 stipulated timeframes. e. The agency will keep all incident reports on file for inspection for governmental authorities. f. New hires and returning staff will be retrained in incident reporting prior to hire/return and annually thereafter. g. The agency will conduct at least quarterly self-audits to ensure this standard is met including cross walking Level I,II, & III progress	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 29 notes to incident reports. Specifically, the provider will ensure that in addition to reporting allegations to the HCPR (24 Hour report and 5-day working report, Incidents involving allegations against staff will be reported in IRIS. V536: Brighter Dayz will comply with all requirements of 10A NCAC 27E .0107 including: a. The agency will choose one Training On Alternatives To Restrictive Interventions curricula that all staff must complete by a qualified trainer as defined in NCAC 27E .0108 . The curriculum will a curriculum approved by the NC DMH/IDD/SAS (mental health/intellectual developmental disability/substance abuse services) on their list of approved curricula. b. The agency will ensure all newly hired and returning staff have valid Training On Alternatives To Restrictive Interventions certificate on file before working and annually thereafter. c. The agency will conduct at least quarterly self-audits to ensure this standard is met. V537: Brighter Dayz will comply with all requirements of NCAC 27E .0108. ED was retrained as part of October POC (plan of correction). Certificate if training for CPI (Crisis Prevention Institute) training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Describe your plans to make sure the above happens. Brighter Dayz will: a. Contract with a Certified Forensic Health Care Auditor for three months to: 1. Conduct quarterly self-audits of the agency to sure compliance with this POP (plan of protection) and any subsequent POC. The self-audits will be in the record.	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 30 2. Obtain distinct clarification from DHSR/other providers/Forensic Auditor regarding treatment strategies of prior behaviors/employment. 3. Consult with IRIS coordinator for IRIS training. 4. Shift MAR responsibility to Executive Director. 5. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live online. 6. Conduct competency-based training with the Qualified Professional and Executive Director. The initial training will be live or live online. b. The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented." Review on 4/13/21 of the second Plan of Protection written by Licensee #1/Director/Qualified Professional #1 dated 4/13/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? V109: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision. " Client who was working has been discharged as of December 2019. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Brighter Dayz 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 by April 30, 2021 about: 1. technical knowledge;	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 31 2. cultural awareness; 3. analytical skills; 4. decision-making; 5. interpersonal skills; 6. communication skills; and 7. clinical skills. Specifically, QP will attend training on PCP's by April,18,2021 highlighting the HOW/SUPPORT section. V110: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision. " Client who was working has been discharged as of December 2019. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Specifically, ED will attend training on the above by a qualified trainer by 4/30/21 in the areas below: 8. technical knowledge; 9. cultural awareness; 10. analytical skills; 11. decision-making; 12. interpersonal skills; 13. communication skills; and 14. clinical skills. V112: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The client who was employed has been discharged since December 2019. " Client that is currently in our care cannot and will not work without adequate supervision. Brighter Dayz will comply with all requirements of 10A NCAC 27G .0205 including: a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter	V 293		

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 32	V 293		

referred to as the "plan," strategies to address the client's presenting problem shall be documented.
b. Specifically, Clients will not be able to obtain employment unless staff is present for the entire work shift.
c. Specifically, QP will ensure that general supervision is provided to all clients to prevent (AWOL/ELOPEMENT). Any client who had a history of AWOL within the past 12 months will have a specific supervision plan under the How/Intervention section of the goal. QP will document prior histories and have a meeting which will serve to establish which histories/behaviors are still a concern, and develop strategies based on those concerns.
V118:
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
" As of 3/01/21 the staff who was setting up the Medication Administration Record (MAR) is no longer doing so. This responsibility has been shifted to the Executive Director.
Brighter Dayz will comply with all requirements of 10A NCAC 271g .0209 including ensuring all direct care staff have documented training by qualified trainer in the following topics:
a. Medication dispensing:
Medication packaging and labeling
b. Medication administration
c. Medication disposal
d. Medication Storage
e. Medication review
f. Medication education
g. Medication errors
The MAR will be audited weekly by the Executive Director for conformance with standards.
V367:
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
" The QP will ensure that in addition to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 33	V 293		

reporting allegations to the HCPR involving staff , Incidents involving allegations against staff will also be reported in IRIS within 72 hours.
Brighter Dayz will comply with all requirements of 10A NCAC 27g .0603/.0604 including:
d. Ensuring that all Level II and III incidents are reported to DHSR and the LME/MCO as required by the prevailing NC DHHS Incident Reporting System (IRIS) within the IRIS and 10A NCAC 27g .0604 stipulated timeframes.
e. The agency will keep all incident reports on file for inspection for governmental authorities.
f. The agency will conduct at least quarterly self-audits to ensure this standard is met including cross walking Level I,II, & III progress notes to incident reports.
V536: Brighter Dayz will comply with all requirements of 10A NCAC 27E .0107
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
" ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.)
Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work.
The ED will monitor CPI certification monthly.
V537:
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
" ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.)
Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work.

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 34 The ED will monitor CPI certification monthly. V293: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: Cross reference response to V109,110,112,118, 132, 367, 536, 537, 736, 738 Describe your plans to make sure the above happens. Brighter Dayz will: c. Contract with a Certified Forensic Health Care Auditor for three months to: 1. Conduct quarterly self-audits of the agency to sure compliance with this POP and any subsequent POC. The self-audits will be in the record. 2. Obtain distinct clarification from DHSR/other providers/Forensic Auditor regarding treatment strategies of prior behaviors/employment. 3. Consult with IRIS coordinator for IRIS training, and specifically regarding Incident report after submitting HCPR. 4. Shift MAR responsibility to Executive Director. 5. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live or online. 6. Conduct competency-based training with the Qualified Professional and Executive Director. The initial training will be live or live online. Any documents submitted to auditor will be signed off by auditor. d. The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented. e. Agency will request informal conference to discuss implementations made by provider." Review on 4/15/21 of the third and final Plan of	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 35 Protection written by Licensee #1/Director/Qualified Professional #1 dated 4/15/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? V109: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision. " Client who was working has been discharged as of December 2020. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Brighter Dayz 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 by April 30, 2021 about: 1. technical knowledge; 2. cultural awareness; 3. analytical skills; 4. decision-making; 5. interpersonal skills; 6. communication skills; and 7. clinical skills. Specifically, QP will attend training on PCP's by April,18,2021 highlighting the HOW/SUPPORT section. V110: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision. " Client who was working has been discharged as of December 2020. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Specifically, ED will attend training on the above	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 36 by a qualified trainer by 4/30/21 in the areas below: 8. technical knowledge; 9. cultural awareness; 10. analytical skills; 11. decision-making; 12. interpersonal skills; 13. communication skills; and 14. clinical skills. V112: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The client who was employed has been discharged since December 2020. " Client that is currently in our care cannot and will not work without adequate supervision. Brighter Dayz will comply with all requirements of 10A NCAC 27G .0205 including: a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. b. Specifically, Clients will not be able to obtain employment unless staff is present for the entire work shift. c. Specifically, QP will ensure that general supervision is provided to all clients to prevent (AWOL/ELOPEMENT). Any client who had a history of AWOL within the past 12 months will have a specific supervision plan under the How/Intervention section of the goal. QP will document prior histories and have a meeting which will serve to establish which histories/behaviors are still a concern, and develop strategies based on those concerns. V118: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " As of 3/01/21 the staff who was setting up the	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 37 Medication Administration Record (MAR) is no longer doing so. This responsibility has been shifted to the Executive Director. Brighter Dayz will comply with all requirements of 10A NCAC 271g .0209 including ensuring all direct care staff have documented training by qualified trainer in the following topics: a. medication dispensing: Medication packaging and labeling b. Medication administration c. Medication disposal d. Medication Storage e. Medication review f. Medication education g. Medication errors The MAR will be audited weekly by the Executive Director for conformance with standards. V367: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The QP will ensure that in addition to reporting allegations to the HCPR involving staff , Incidents involving allegations against staff will also be reported in IRIS within 72 hours. Brighter Dayz will comply with all requirements of 10A NCAC 27g .0603/.0604 including: d. Ensuring that all Level II and III incidents are reported to DHSR and the LME/MCO as required by the prevailing NC DHHS Incident Reporting System (IRIS) within the IRIS and 10A NCAC 27g .0604 stipulated timeframes. e. The agency will keep all incident reports on file for inspection for governmental authorities. f. The agency will conduct at least quarterly self-audits to ensure this standard is met including cross walking Level I,II, & III progress notes to incident reports. V536: Brighter Dayz will comply with all requirements of 10A NCAC 27E .0107 To ensure the health, safety and welfare of clients	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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
V 293	Continued From page 38 Brighter Dayz will take the following actions: " ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work. The ED will monitor CPI certification monthly. V537: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work. The ED will monitor CPI certification monthly. V293: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: Cross reference response to V109,110,112,118, 132, 367, 536, 537, 736, 738 Describe your plans to make sure the above happens. Brighter Dayz will: a. Contract with a Certified Forensic Health Care Auditor for three months to: 1. Conduct quarterly self-audits of the agency to sure compliance with this POP and any subsequent POC. The self-audits will be in the record. 2. Obtain distinct clarification from DHSR/other providers/Forensic Auditor regarding treatment strategies of prior behaviors/employment.	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 39 3. Consult with IRIS coordinator for IRIS training, and specifically regarding Incident report after submitting HCPR. 4. Shift MAR responsibility to Executive Director. 5. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live or online. 6. Conduct competency-based training with the Qualified Professional and Executive Director. The initial training will be live or live online. Any documents submitted to auditor will be signed off by auditor. b. The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented. c. Agency will request informal conference to discuss implementations made by provider." Client #1 was 16 years old and diagnosed with Depressive Disorder, Trauma Stressor, and Disruptive Mood Dysregulation Disorder. She had a history of repeated AWOL (absent without leave) with episodes lasting up to one month at a time, overdose, suicide attempts, cutting, and verbal and physical altercations. She was job placed at a local fast food restaurant within one month of being admitted to the facility with no assessment to determine the ability to work unsupervised. Client #2 was 14 years old and diagnosed with Post-Traumatic Stress Disorder and Major Depressive Disorder. He had a history of AWOL, self-injurious behaviors and suicidal ideation. No treatment plan strategies were developed to address Client #1 and Client #2's histories of repeated AWOL or self-harm behaviors. Former Staff #4 did not have a valid driver's	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 293	Continued From page 40	V 293		

license. Former Staff #4 was instructed by Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director to transport Client #1 and Client #2 in the company vehicle despite the lack of a valid driver's license. Furthermore, Former Staff #3 and Former Staff #4 brought Client #1 and Client #2 to their personal homes.

Client #1 was prescribed medications to address her mental health needs (Prazosin HCl used to treat nightmares and insomnia which can increase suicide risk, Abilify used to treat mood disorders and depression, Mirtazapine used to treat depression and restore the balance of neurotransmitters, and Zoloft used to treat depression, panic attacks and anxiety). Due to lack of documentation on Client #1's February, 2021 medication administration record, it was impossible to determine if Client #1 received her medications as ordered by the physician. Furthermore, all staff responsible for administration of Client #1's medications during the first week of February, 2021 did not report the lack of documentation associated with Client #1's medication administration.

The facility did not complete the necessary notifications after an allegation of Former Staff #3 offering marijuana to Client #1. Additionally, there was no evidence of Licensee #2/Executive Director having current training in alternatives to restrictive intervention and seclusion, physical restraint, and isolation time-out.

Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director did not provide the clinical and administrative oversight required to meet the needs of Client #1 and Client #2 resulting in continued neglect.

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V 293	Continued From page 41 This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 293		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required	V 367		

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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V 367	Continued From page 42	V 367		

report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 367	Continued From page 43 (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level III incidents to the LME (local management entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 2/17/21 of facility's Internal Investigations revealed: -Undated 24-Hour Initial Report to Health Care Personnel Registry (HCPR) regarding an allegation of neglect for Former Staff #3 offering marijuana to Client #1; -Undated 5-Working Day Report to HCPR regarding an allegation of neglect involving Former Staff #3 offering marijuana to Client #1. The 5-Working Day Report indicated the 24-Hour Initial Report to HCPR was sent on 1/5/21. " ...Client (Client #1) stated to her social worker a staff offered her drugs (marijuana). ED (Licensee #2/Executive Director) and QP (Licensee	V 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 367	Continued From page 44	V 367		

#1/Director/Qualified Professional #1) questioned all clients & staff. During investigation QP & ED didn't get answers as to where or when. Client story changed. Client told QP & ED several different stories recanting what she told her social worker. Staff accused was terminated before the incident/allegation was brought to our attention;"
-Statement summary provided by Former Staff #3 to Licensee #1/Director/Qualified Professional #1 dated 1/5/21 revealed Former Staff #3 denied the allegations of offering Client #1 marijuana.

Review on 2/17/21 of the facility's Incident Reports revealed:
-There was no Level III incident report completed regarding the allegation of Former Staff #3 offering marijuana to Client #1 in January, 2021.

Interview on 2/17/21 with Client #1 revealed:
-Was offered marijuana by Former Staff #3.

Multiple attempted interviews with Former Staff #3 were unsuccessful. Phone messages were left for Former Staff #3 requesting a call back on 2/23/21, 2/24/21, 2/25/21, and 3/22/21. Additionally, a text message was sent on 3/22/21 but was marked at "Not Delivered!"

Interview on 2/17/21 with Licensee #1/Director/Qualified Professional #1 revealed:
-There was an allegation reported by Client #1 to her Department of Social Services Social (DSS) Worker against Former Staff #3 that Former Staff #3 offered marijuana to Client #1;
-The facility notified HCPR via the 24-Hour Initial Report and 5-Working Day Report and an internal investigation was completed;
-First heard about the allegation when the local DSS arrived at the facility to investigate;
-Client #1 never mentioned any concerns to

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 367	Continued From page 45 Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director about Former Staff #3 offering marijuana to her; -Was unable to substantiate that Former Staff #3 offered marijuana to Client #1 but terminated Former Staff #3 for an unrelated matter; -Was not aware that a Level III incident report needed to be completed regarding allegations of abuse or neglect. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -NC IRIS reports are the responsibility of direct care staff, Licensee #1/Director/Qualified Professional #1, and the Licensed Professional. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Direct care staff along with Licensee #1/Director/Qualified Professional #1 are responsible for completing reports in NC IRIS and then the Licensed Professional will sign off on the reports. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -Did not report the allegation through NC IRIS (North Carolina Incident Response Improvement System) because in the NC IRIS handbook it reveals that all allegations are to be reported to HCPR; -Licensee #2/Executive Director revealed she spoke with the LME representative who handled IRIS and never discussed the HCPR information could be entered through IRIS. This deficiency constitutes a recited deficiency.	V 367		

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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 367	Continued From page 46 This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	V 536		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 536	Continued From page 47 (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 536	Continued From page 48 by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include:	V 536		

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 536	Continued From page 49 (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were trained in alternatives to restrictive interventions affecting 1 of 10 audited staff members (Licensee #2/Executive Director). The findings are: Review on 3/17/21 of Licensee #2/Executive Director's record revealed: -Hire date 8/1/18; -Training certificate for alternatives to restrictive intervention training through Nonviolent Crisis Intervention program issued 10/23/19 with expiration date 10/23/20; -No additional information regarding training for alternatives to restrictive intervention was	V 536		

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 536	Continued From page 50 available for review. Interview on 2/23/21 with Former Staff #4 revealed: -During surveys and investigations, Licensee #1/Director/Qualified Professional #1 would call and text staff and talk to them about getting their stories straight before speaking with surveyors and investigators; -Upon telling the truth about the facility to a Department of Social Services (DSS) staff member, she stopped getting calls and texts from Licensee #1/Director/Qualified Professional #1. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Was trained in Nonviolent Crisis Intervention. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -Not sure why Licensee #2/Executive Director's most current certificate for training in Nonviolent Crisis Intervention was not provided but the training was completed in October, 2020. This deficiency constitutes a recited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 537	Continued From page 51 (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene	V 537		

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FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 537	Continued From page 52 (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence	V 537		

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	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 53 by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH NEW START	4460 HUNTINGTON DRIVE GASTONIA, NC 28056

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V 537	Continued From page 54 (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were trained in seclusion, physical restraint, and isolation time-out affecting 1 of 10 audited staff members (Licensee #2/Executive Director). The findings are: Review on 3/17/21 of Licensee #2/Executive Director's record revealed: -Hire date 8/1/18; -Training certificate for seclusion, physical restraint, and isolation time-out through Nonviolent Crisis Intervention program issued 10/23/19 with expiration date 10/23/20. Interview on 2/23/21 with Former Staff #4 revealed: -During surveys and investigations, Licensee	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 55 #1/Director/Qualified Professional #1 would call and text staff and talk to them about getting their stories straight before speaking with surveyors and investigators; -Upon telling the truth about the facility to a Department of Social Services (DSS) staff member, she stopped getting calls and texts from Licensee #1/Director/Qualified Professional #1. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Was trained in Nonviolent Crisis Intervention. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -Not sure why Licensee #2/Executive Director's most current certificate for training in Nonviolent Crisis Intervention was not provided but the training was completed in October, 2020. This deficiency constitutes a recited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Failure to Correct Type A1.	V 537		