STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74121 2741	or contraction	IDEITH IO/HIGH HOMBER.	A. BUILDING: _			
		MHL036-336	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
FRESH N	EW START		TINGTON DRIV A, NC 28056	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	on 4/16/21 as a resulticensees after the infineld on 12/2/20. The substantiated (Intake were cited. The facility is licensed	#NC173231). Deficiencies If for the following service 27G .1700 Residential				
V 109	27G .0203 Privileging	/Training Professionals	V 109			
	QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be no qualified professional (b) Qualified professi professionals shall de and abilities required (c) At such time as a employment system i then qualified profess professionals shall de (d) Competence sha exhibiting core skills i (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making; (5) interpersonal skil (6) communication s (7) clinical skills. (e) Qualified professi NCAC 27G .0104 (18)	ssionals privileging requirements for s or associate professionals. conals and associate emonstrate knowledge, skills by the population served. competency-based s established by rulemaking, conals and associate emonstrate competence. If be demonstrated by including: dge; sss; lls; kills; and onals as specified in 10 A)(a) are deemed to have of the competency-based				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED	
		MHL036-336	B. WING	B. WING		R / 16/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	<u> </u>		
		4460 HUI	NTINGTON DRIVI	E			
FRESH N	EW START	GASTON	IA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 109	develop and impleme for the initiation of an plan upon hiring each (g) The associate pro supervised by a quali	dy for each facility shall ent policies and procedures individualized supervision a associate professional.	V 109				
	This Rule is not met Based on interview a audited qualified profi #1/Director/Qualified demonstrate the know required by the popul are:	as evidenced by: nd record review, 1 of 2 essionals (Licensee Professional #1) failed to wledge, skills, and abilities ation served. The findings					
	revealed: -Hire date of 2/1/18; -Was retrained in Firs Resuscitation, Bloods Medication Administra Mental Health/Develor Disabilities/Substance Specific Trainings, Al Intervention, Seclusion Isolation Time-Out, Of Confidentiality, Popul Documentation, Crisis Management, Person	Professional #1's record st Aid, Cardiopulmonary corne Pathogens, ation, Seizure Management, commental e Abuse Services, Client ternatives to Restrictive on, Physical Restraint, and crientation, Rights and ation Served,					

Division of Health Service Regulation

STATE FORM 94HW11 If continuation sheet 2 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		MHL036-336	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
EDEOU N	EW OTA DT	4460 HU	NTINGTON DRIV	E	
FRESH N	EW START	GASTON	IIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 109	Continued From page	2	V 109		
	Aggressive Youth, an Improvement System	d Incident Response during October, 2020.			
	Review on 4/1/21 of L #1/Director/Qualified				
	Description revealed:	1 1010331011d1 # 1 3 00b			
	-Job description signe	-			
	#1/Director/Qualified	Professional #1 dated esponsibilities included "			
		ssociate professionals and			
	para-professionals, o	versight of emergencies,			
	·	cho educational services to			
		ts, participation in treatment pordination of each child or			
		nt plan, provision of basic			
	case management fu	nctions"			
	Review on 3/18/21 of	the Statement of			
		ed as a result of 9/29/20			
	Division of Health Ser	vice Regulation (DHSR)			
	survey revealed:	/Qualified Professional #1			
	was cited for failure to				
		d abilities required by the			
		ited 9/29/20 written and			
	signed by Licensee #				
		aled: "will comply with all NCAC 27G .0203 including			
	ensuring the compete				
	Professional. Specific				
		ive training by a qualified echnical knowledge; cultural			
	•	skills; decision-making;			
	interpersonal skills; co	ommunication skills; and			
	clinical skills"				
	Review on 3/18/21 of	the Plan of Correction			
		e to the 9/29/20 DHSR			
		correction completion date of			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING			
	MHL036-336	B. WING		R 04/16/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FRESH NEW START		TINGTON DRIV	E		
	GASTONI	A, NC 28056		_	
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 109 Continued From page	3	V 109			
10/22/20 revealed: -"The agency will co of 10A NCAC 27G .02 competency of the Qu Specifically, the Qualitraining by a qualified knowledge, 2. cultural skills, 4. decision-mak 6. communication skill addition the Qualified by a qualified instruct 2. client rights and commanagement and plar planning conducting a ensure compliance wiperson-centered pla Licensed Mental Heal and approve allpers implementation. The completeness and clir Review on 2/17/21 of -Client #1's treatment most recent update 1/ for AWOL (absent with attempts, or methods when away from the fa history and job placen -Client #1's February, administration record) making it impossible to were administered as NCAC 271g .0209 Me (V118) for specifics). Review on 2/17/21 of	comply with all requirements 203 including ensuring the palified Professional. Fied Professional will receive trainer in: 1. technical awareness, 3. analytical awareness, 15. In Professional will be trained or in 1. cultural competency, infidentiality, 3. crisis aning, 4. person-centered admission assessments. To the standards around amning the agency's the Professional will review son-centered plans prior to plans will be reviewed for inical appropriateness" Client #1's record revealed: plan dated 9/21/20 with 7/21 revealed no strategies nout leave), self-harm of ensuring supervision acility despite the client's ment; 2021 MAR (medication acility despite the client's ment; 2021 MAR (medication acility despite the client's ment; 2021 MAR (medication acility despite the 10 A adication Requirements Client #2's record revealed: plan dated 10/26/20 with 14/21 revealed no ar self-harm attempts	V 109			

Division of Health Service Regulation

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ` ′	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			R	
		MHL036-336	B. WING			/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
FRESH N	EW START		ITINGTON DRIV A, NC 28056	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 109	Continued From page	2 4	V 109				
	regarding the allegation offering marijuana to Review on 2/17/21 of revealed: -No state issued drived Interview on 2/17/21 of the Had a job in Novembre restaurant and worke -Staff did not visit her when they took her more than the staurant and worke when they took her more restaurant and worke -Staff did not visit her when they took her more restaurant and worke -Staff did not visit her when they took her more restaurant and worke -Staff did not visit her when they took her more restaurant and worke -Staff did not visit her when they took her more restaurant and worker restaurant and wor	III incident report completed on of Former Staff #3 Client #1 in January, 2021. Former Staff #4's record er's license in the record. with Client #1 revealed: per, 2020 at a local fast food					
	-Went AWOL from the was missing for 3-4 h -Did not know where AWOL; -Had \$100 from his C when he went AWOL knife because he "" -Was found by local la AWOL before he coul taken to the hospital a lnterview on 2/17/21 revealed: -Did not have a valid -Licensee #1/Director and Licensee #2/Exe not have a valid drive -Provided a state issue.	thristmas money with him so he could purchase a wanted to gut myself;" aw enforcement during the d harm himself and was and admitted. with Former Staff #4 driver's license; t/Qualified Professional #1 cutive Director knew she did					

Division of Health Service Regulation

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DIVISION	or riealin Service Negu	lation	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
MHL036-336 B. WING 04/16				04/16/20	21	
			•			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
EDEOU NE	-14/ OTA DT	4460 HUN	TINGTON DRIV	Œ		
FRESH NE	EW START	GASTONI	A, NC 28056			
	OLIMANA DV. OT.			DDOWDEDIO DI ANI OF CODDECTION		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
170		,	IAG	DEFICIENCY)		
			+			
V 109	Continued From page	5	V 109			
	. •					
		ve Client #1 and Client #2 in				
	the company vehicle I	by Licensee				
	#1/Director/Qualified I	Professional #1 and				
	Licensee #2/Executive	e Director despite that they				
		e a valid driver's license;				
		nvestigations, Licensee				
		_				
		Professional #1 would call				
		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				
	-	ting calls and texts from				
		Qualified Professional #1.				
	LICENSEE I/DITECTOR/G	dailled i Tolessional #1.				
	It	idale I de como e				
	Interview on 2/17/21 v					
		Professional #1 revealed:				
	-Was responsible for	developing the treatment				
	plan goals and strate	gies.				
	-Not sure why there a	re marks crossing out the				
	first several days of m	nedications administration				
	on Client #1's Februa					
	-Would need to ask th	•				
		notation of medication				
		eral days during the first				
	week of February, 202					
	-The House Manager					
	overseeing the MARs	i.				
	Interview on 3/31/21 v	with Licensee				
	#1/Director/Qualified	Professional #1 revealed:				
	-Was responsible for	developing treatment plan				
	goals and strategies;					
		ıld have furnished a valid				
	driver's license:	ad have fairhoriou a valid				
	,	ard and natify DUCD				
		ord and notify DHSR survey				
	staff;					
	-Was not aware a Le					
	needed to be complete	ted regarding allegations of	1			

Division of Health Service Regulation

abuse or neglect.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
					D
		MHL036-336	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
			NTINGTON DRIVE		
FRESH N	EW START		IIA, NC 28056		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 109	Continued From page	: 6	V 109		
	having a valid driver's review after being red 3/31/21 with Licensee	e regarding Former Staff #4 license was provided for uested during interviews on #1/Director/Qualified icensee #2/Executive			
	This deficiency consti	tutes a recited deficiency.			
		ss-referenced into 10A ope (V293) for a Failure to			
V 110	27G .0204 Training/S Paraprofessionals	upervision	V 110		
	SUPERVISION OF PA (a) There shall be no paraprofessionals. (b) Paraprofessionals associate professional professional as specifications.	ied in Rule .0104 of this			
	population served. (d) At such time as a employment system is then qualified profess	competency-based s established by rulemaking, ionals and associate monstrate competence. I be demonstrated by			
	 (1) technical knowled (2) cultural awarened (3) analytical skills; (4) decision-making; (5) interpersonal skill 	dge; ss;			

Division of Health Service Regulation

STATE FORM 94HW11 If continuation sheet 7 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R
		MHL036-336	B. WING		04/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH N	EW START		TINGTON DRIV A, NC 28056	Έ	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 110	Continued From page	e 7	V 110		
	(6) communication s(7) clinical skills.(f) The governing bodevelop and implement	skills; and dy for each facility shall ent policies and procedures e individualized supervision			
	audited paraprofession Director) failed to den skills, and abilities red served. The findings Review on 3/17/21 of Director's record reversities date of 2/1/18. -Was retrained in First Resuscitation, Bloods Medication Administra Mental Health/Developisabilities/Substance	and record review, 1 of 7 conals (Licensee #2/Executive monstrate the knowledge, quired by the population are: Licensee #2/Executive ealed: St Aid, Cardiopulmonary corne Pathogens, ation, Seizure Management, suppmental e Abuse Services, Client ghts and Confidentiality, crisis Planning and			
	Correction, Documen Planning, Cultural Co Accessibility of Recor Youth, and Incident R System during Octob	tation, Person Centered impetency, Security and rds, Sexually Aggressive desponse Improvement er, 2020. Licensee #2/Executive otion revealed:			

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
			A. BOILDING			
			5 14/11/6		R	
		MHL036-336	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4460 HUN	ITINGTON DRIV	'E		
FRESH N	EW START		A, NC 28056			
0(1) ID	STIMMADV ST.	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF CORRECTIO	N	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
V 110	Continued From page	e 8	V 110			
		dated 2/3/18 revealed job				
	responsibilities includ	•				
	resources) records, c					
	process, MARs (medi					
	records) planning out authorizations, comm					
		care organizations/local				
), DSS (Department of				
		SR (Division of Health				
	Service Regulation), I					
	,	nile Justice), etc. schedule				
		ancial management, develop				
	_	rformance, handle conflict				
	with staff and client, a					
		ming different task that can				
	vary by setting"	3				
	Review on 3/18/21 of	the Statement of				
	Deficiencies complete	ed as a result of 9/29/20				
	Division of Health Sei	rvice Regulation (DHSR)				
	survey revealed:					
		ve Director was cited for				
		e the knowledge, skills, and				
	abilities required by the	• •				
		ated 9/29/20 written and				
	signed by Licensee #					
		aled: "will comply with all				
		NCAC 27G .0204 including				
	ensuring the compete	fically, newly hired and				
	· ·	sionals will receive training				
	by a qualified trainer					
	technical knowledge,	-				
		ion-making, interpersonal				
		skills, and clinical skills"				
	,	,				
	Review on 2/17/21 of	Client #1's record revealed:				
		plan dated 9/21/20 with				
		/7/21 revealed no strategies				
		hout leave), self-harm				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R	
	MHL036-336	B. WING		04/16/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRESH NEW START		TINGTON DRIV A, NC 28056	E		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 110 Continued From page 9 attempts, or methods of e when away from the facil history and job placemen -Client #1's February, 202 administration record) individe making it impossible to divere administered as ord NCAC 271g .0209 Medici (V118) for specifics). Review on 2/17/21 of Clie-Client #2's treatment pla most recent update 1/14/strategies for AWOL or se despite the client's history. Review on 2/17/21 of the Reports revealed: -There was no Level III in regarding the allegation of offering marijuana to Clie Review on 2/17/21 of For revealed: -No state issued driver's linterview on 2/17/21 with -Had a job in November, restaurant and worked the -Staff did not visit her at when they took her medic food restaurant to adminisher. Interview on 2/17/21 with -Went AWOL from the growas missing for 3-4 hours -Did not know where he wawoL;	lity despite the client's ant; 21 MAR (medication cluded several blanks letermine if medications dered (Refer to 10A cation Requirements ent #2's record revealed: an dated 10/26/20 with /21 revealed no elf-harm attempts y. e facility's Incident incident report completed of Former Staff #3 ent #1 in January, 2021. Incense in the record. In Client #1 revealed: 2020 at a local fast food here for 4-5 days; work except for one time feations to the local fast ister the medications to In Client #2 revealed: oup home one time and is;	V 110	DETIGIENCY)		

Division of Health Service Regulation

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			(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		A. BOILDING		R
N	IHL036-336	B. WING		04/16/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH NEW START		INGTON DRIV	E	
		, NC 28056		
(X4) ID SUMMARY STATEMENT : PREFIX (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENT	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 110 Continued From page 10		V 110		
when he went AWOL so he countries because he " wanted to a WOL before he could harm taken to the hospital and admanded to find employment the second have a valid driver's and Licensee #1/Director/Qualified and Licensee #2/Executive Director and Licensee #1/Director/Qualified and Licensee #2/Executive Director and Licensee #2/Executive Director and Licensee #2/Executive Director and the company vehicle by Licensee #1/Director/Qualified Professis Licensee #2/Executive Director and text staff and talk to them stories straight before speaking and investigators; -Upon telling the truth about to Department of Social Service member, stopped getting calls Licensee #1/Director/Qualified Interview on 3/31/21 with Licensee #1/Director/Qualified Interview on 3/31/21 with Licensee #1/Director/Qualified Professions and text staff and talk to them stories straight before speaking and investigators; -Upon telling the truth about to Department of Social Service member, stopped getting calls Licensee #1/Director/Qualified Interview on 3/31/21 with Licensee #1/Director/Qualified Professions and service member, stopped getting calls Licensee #1/Director/Qualified Professions and service member, stopped getting calls Licensee #1/Director/Qualified Professions and service member, stopped getting calls Licensee #1/Director/Qualified Professions and service member, stopped getting calls Licensee #1/Director/Qualified Professions and service member, stopped getting calls Licensee #1/Director/Qualified Professions and service member and se	to gut myself;" cement during the himself and was aitted; but " [Licensee would set myself up alls" mer Staff #4 cicense; ded Professional #1 cirector knew she did se; diffication card when a valid driver's t #1 and Client #2 in see onal #1 and or despite that they a driver's license; diver's license; diver's licensee onal #1 would call about getting their about getting their and with surveyors the facility to a se (DSS) staff and texts from ded Professional #1. ensee #2/Executive behind the house ded Professional #1	V 110		

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL036-336	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH NI	EW START		TINGTON DRIV A, NC 28056	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 110	-When asked why Cli a line through severa administration in the I responded "I don't -Former Staff #4 had -Took a copy of all state -Will re-check Former sure there wasn't and and will re-send it. Interview on 4/8/21 w Director revealed: -Did not report the all offering marijuana to (North Carolina Incide System) because in the revealed that all alleghted HCPR (Health Care Felicensee #2/Executives spoke with the LME (representative who had iscussed the HCPR entered through IRIS. No additional evidency having a valid driver's review after being received after being	ent #1's February, 2021 had I days of medication beginning of the month know;" a valid driver's license; aff driver's licenses at hire; r Staff #4's record and make other page not sent to DHSR with Licensee #2/Executive regation of Former Staff #3 Client #1 through NC IRIS ent Response Improvement the NC IRIS handbook it ations are to be reported to Personnel Registry); red Director revealed she Local Management Entity) andled IRIS and never information could be	V 110		
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112		

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-336 STREET ADDRES SH NEW START SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A. BUILDING: _		
		MHL036-336	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	,
			TINGTON DRIV		
FRESH NE	EWSTART	GASTONIA	A, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
V 112	Continued From page	: 12	V 112		
	PLAN (c) The plan shall be assessment, and in plegally responsible per of admission for client receive services beyond (d) The plan shall incomprojected date of achieved by provision projected date of achieved by strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a provider stating why sobtained. This Rule is not met a Based on interview and failed to develop and	developed based on the artnership with the client or arson or both, within 30 days is who are expected to and 30 days. Italian are anticipated to be of the service and a evement; view of the plan at least on with the client or legally both; on or assessment of t; and r agreement by the client or a written statement by the such consent could not be			
	clients (Client #1 and are:	Client #2). The findings			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MHL036-336 MHL036-336 MHL036-336 E. WING DENTIFICATION NUMBER: MHL036-336 E. WING DENTIFICATION DRIVE FRESH NEW START STREET ADDRESS, CITY, STATE, ZIP CODE 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 17/21 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-10 secontification revealed: -Cross-reference to Correction (EACH CORRECTION SHOULD BE CROSS-REFERENCED 10 THE APPROPRIATE DEFICIENCY) V 112 V 113 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; -17 years of the APPROPRIATE Revealed The APPROPRIATE DEFICIENCY V 112 V 1
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-Crisis plan notation revealed: "To be completed upon completion of admission quarantine process
upon completion of admission quarantine process
due to COVID 10 presentions/protocols:"
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.
or sen-narm attempts despite the chefit's flistory.
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;

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STATEMEN	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			- CONSTRUCTION	COMPLI		
			A. BOILDING			
			B. WING		R 04/16/2021	
		MHL036-336	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
EDEQU N	EW STADT	4460 HUN	ITINGTON DRIV	E		
FRESH N	RESH NEW START GASTONIA		IA, NC 28056			
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V 112	Continued From page	14	V 112			
	when they took her m	at work except for one time edications to the local fast ninister the medications to				
	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 went AWOL, she four on and was pacing th as Client #2 was alwa	shift the night Client #2 d Client #2 had his clothes e floor which was unusual ys prepared for bed when				
	his bedroom and Staf -Upon investigating w Client #2 exiting the fa window;					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.25		R
MHL036-336 B. WING			04/16/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
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	OLIMANA DV. OT		A, NC 28056	DROWDERIO DI AN OF CORRECTIO	
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V 112	Continued From page	e 15	V 112		
	-Client #2 was located and was taken to the	d by local law enforcement hospital.			
	-Worked the night Client #2 had gone to door; -Heard a loud thump #2 but he had gone o -Verbally prompted C not respond; -Called local law enformation of the content of th	o his room and closed the and went to check on Client ut the window; lient #2 to return but he did rcement. with Licensee Professional #1 revealed: developing treatment plan ody" and did not work			
	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;"				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		, , ,	E SURVEY PLETED
		MIII 000 000	B. WING			R
		MHL036-336			04	/16/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI			
FRESH N	EW START		NTINGTON DRIVE			
	I		IIA, NC 28056			
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V 112	Continued From page	e 16	V 112			
	he jumped out of his to check on him. Loc	L. Staff heard a boom and window when the staff went al law enforcement was er said why he went AWOL.				
	exit meeting revealed -When asked if there to present or commer information was provi	Professional #1 and e Director during the survey : was additional information ats to make, no additional ded by either Licensee Professional #1 or Licensee				
	This deficiency const	itutes a recited deficiency.				
		ss-referenced into 10A ope (V293) for a Failure to				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, incluadministered only by unlicensed persons to pharmacist or other leprivileged to prepare					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		MHL036-336	B. WING			R J/16/2021
					04	1/16/2021
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FRESH N	EW START		IIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	all drugs administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recorded.	d to each client must be kept administered shall be after administration. The following:	V 118			
	physician affecting 1 findings are: Review on 2/17/21 ar record revealed: -Admitted 10/26/20; -Diagnosed with Dep Stressor, Disruptive M Disorder; -16 years old; -Physician's orders do (used to treat nightmat can increase suicide (capsule) daily and A	ecord review, and ty failed to ensure ministered as ordered by the of 2 clients (Client #1). The and 3/16/21 of Client #1's				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU		A. BUILDING: _		COMPLETED	
		MHL036-336	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
		4460 HUN	INGTON DRIV	Æ	
FRESH N	EW START	GASTONIA	, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 118	the balance of neurot (tablet) daily; -Physician's orders da to treat depression, p 25mg 1 tab daily; -February, 2021 MAR -no documentation -no documentatio	ated 10/26/20 for treat depression and restore ransmitters) 15mg 1 tab ated 12/9/20 for Zoloft (used anic attacks and anxiety) a revealed: on of administration of gh 2/3/21; on of administration of zoloft rough 2/5/21; on of administration of Abilify on of administration of Abilify ith Staff #2 revealed: ations in the mornings; ues with not having all the the client MARs; les before administering e name of the prescription, how often the medication is of the client, and match the ith the Associate lies ations to the clients;	V 118		
	-The House Manager MARs. Interview on 3/22/21 v revealed:	oblems with the MARs; was responsible for the with the House Manager			
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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		MHL036-336	B. WING	04/10		6/2021
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EDECH NI	EW START	4460 HUN	ITINGTON DRIVE	Ξ		
FRESH N	EWSIAKI	GASTON	IA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	e 19	V 118			
V 118	days of the month; -"I messed up the I the MARs. [Licensee over the MARs. Not -Was unable to identi administered properly February, 2021. Interview on 2/17/21 f #1/Director/Qualified -Not sure why there a first several days of n Client #1's February, -Would need to ask th regarding the lack of	MARs. I am no longer over #2/Executive Director] is even sure what I did;" fy if the medications were a during the first few days of with Licensee Professional #1 revealed: Fire marks crossing out the medication administration on 2021 MAR; Fine House Manager motation of medication eral days of the first week of the was responsible for	V 118			
	-Was possible he adr the facility since 2/1/2 would need to check did administer medical -The medication adm to administer medical medications from a digloves, get the pharm medication packs, per hand the plastic recelling to take the merelling the medical -It was "human error" were not signed as a week of February, 20 -The House Manager ensuring the medical	Professional #1 revealed: ninistered medications at the MARs to determine if he ations; inistration protocol to follow cions was to retrieve the ouble locked cabinet, wear nacy pre-packaged el back the plastic label, otacle to the clients for the dications; that Client #1's medications dministered during the first 21; was responsible for				

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PRINTED: 04/29/2021 FORM APPROVED

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	
			A. BUILDING: _			
		MHL036-336	B. WING			⋜ 16/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 0	
TO AVIC OF T	NOVIBER OR GOLFELER		TINGTON DRIV	,		
FRESH N	EW START		A, NC 28056	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	-Believed Client #1 remedications as orders February, 2021 becar from the pharmacy propharmacy fills the orders whought out of it (medwhen they made the medications with the Licensee #2/Executive count. Interview on 3/31/21 shows a count of the pharmacy in put the medication admits and to administer medication at the pharmacy in put the medications in water, swallow and a client's mouth; -When asked why Clistigned as administer MAR she revealed ". -Believed Client #1 remedications as orders february, 2021 becan the back of the label of blister pre-packaged the pill count against These checks were crandom. Interviews on 4/8/21 shows as orders february on 4/8/21 shows a february and magnist these checks were crandom.	decived all of her ed by the physician in use the medications arrive re-packaged and the ers according to the ication administration)" decision to pre-package the pharmacy. Plus, the e Director completes a pill with Licensee #2/Executive rations at the facility since rations was to wear gloves, iner the medications arrive and peel the back label off, in the client's mouth, drink red on the February, 2021I don't know;" received all of her ed by the physician in use she was able to check the top of the package. ompleted weekly and were	V 118			
	exit meeting revealed -When asked if there	: was additional information				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
						R
		MHL036-336	B. WING			16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
FRESH NI	EW START	4460 HUN	ITINGTON DRIVE			
		GASTON	A, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 21	V 118			
	to present or commer information was provi #1/Director/Qualified	nts to make, no additional ded by either Licensee Professional #1 or Licensee during the exit meeting.				
		s medications revealed: abilify 5mg, Mirtazapine				
	Due to the failure to a medication administra determined if clients r as ordered by the phy	ation it could not be received their medications				
	This deficiency consti	itutes a recited deficiency.				
		ss-referenced into 10A ope (V293) for a Failure to				
V 293	27G .1701 Residentia	al Tx. Child/Adol - Scope	V 293			
	children or adolescen free-standing residen intensive, active there interventions within a shall not be the prima who is not a client of (b) Staff secure mea awake during client s shall be continuous a this Section. (c) The population se adolescents who have mental illness, emotion	tment staff secure facility for the its is one that is a stial facility that provides apeutic treatment and system of care approach. It may residence of an individual the facility. In staff are required to be leep hours and supervision as set forth in Rule .1704 of the erved shall be children or e a primary diagnosis of				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURY	
			A. BOILDING.		R	
		MHL036-336	B. WING		04/16/2	2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRESH NE	EW START		INGTON DRIV	E		
	CLIMMADY CT		, NC 28056	DDOWDEDIC DI ANI OF CODDECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	e 22	V 293			
	co-occurring disorder disabilities. These chanot meet criteria for in (d) The children or acrequire the following: (1) removal from community-based restacilitate treatment; and (2) treatment in (e) Services shall be (1) include indivistructure of daily living (2) minimize the related to functional doi: (3) ensure safe control behaviors include management with or (4) assist the clude acquisition of adaptive communication, social (5) support the gaining the skills need intensive treatment set (f) The residential treshall coordinate with the control control in the skills of the clude intensive treatment set (f) The residential treshall coordinate with the control control in the clude intensive treatment set (f) The residential treshall coordinate with the control in the clude intensive treatment set (f) The residential treshall coordinate with the clude in the clude	s including developmental aildren or adolescents shall apatient psychiatric services. dolescents served shall a sidential setting in order to a sidential setting in order to and a staff secure setting. I designed to: vidualized supervision and ag; e occurrence of behaviors deficits; but and deescalate out of auding frequent crisis without physical restraint; and and recreational skills; and child or adolescent in the ded to step-down to a less detting.				
	This Rule is not met Based on interview, robservation, the facili	ecord review, and				

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MHL036-336 B. WING		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURY COMPLETE	
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 Continued From Page 23 Continued From Page 23 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 (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 Parapprofessionals (Licensee #1/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G. 0204 Competencies and Supervision of Parapprofessionals (Licensee #1/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G. 0204 Competencies and Supervision of Parapprofessionals (Licensee #1/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served.						1	
SUMMARY STATEMENT OF DEFICIENCES DID PROVIDERS PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			MHL036-336	B. WING		04/16/2	2021
CASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG	NAME OF P	ROVIDER OR SUPPLIER					
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 293 Continued From page 23 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 (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0205	FRESH NI	EW START			!		
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 (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0205	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE	COMPLETE
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	V 293	supervision and struct the occurrence of beh deficits, ensure safety control behaviors, assadaptive functioning at to step-down to a less affecting 2 of 2 clients. The findings are: CROSS REFERENCI Competencies of Quatassociate Professiona Based on interview are audited qualified profe #1/Director/Qualified demonstrate the known required by the popular CROSS REFERENCI Competencies and Superaprofessionals (Valled Based on interview are audited paraprofessionals (Valled Based on interview are served. CROSS REFERENCI Assessment and Treaservice Plan (V112) Based on interview are failed to develop and address the needs of clients (Client #1 and CROSS REFERENCI Medication Requirem Based on interview, respectively.	ture of daily living, minimize haviors related to functional or and deescalate out of sist in the acquisition of and gaining the skills needed intensive treatment setting (Client #1 and Client #2). E: 10A NCAC 27G .0203 diffied Professionals and als (V109) and record review, 1 of 2 dessionals (Licensee Professional #1) failed to wledge, skills, and abilities action served. E: 10A NCAC 27G .0204 dipervision of 110) and record review, 1 of 7 dipals (Licensee #2/Executive pronstrate the knowledge, quired by the population E: 10A NCAC 27G .0205 diment/Habilitation or and record review, the facility implement strategies to the clients affecting 2 of 2 Client #2). E: 10A NCAC 27G .0209 dents (V118) decord review, and	V 293			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			7 BOILBING.		F	2
		MHL036-336	B. WING		I	6/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
FRESH NE	W START		TINGTON DRIV A, NC 28056	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 293	CROSS REFERENCI Incident Reporting Reand B Providers (V36) Based on interview are failed to report all Lev (local management elecatchment area where within 72 hours of bed incident. CROSS REFERENCI Training on Alternative Interventions (V536) Based on interview are failed to ensure staff to restrictive intervent audited staff members Director). CROSS REFERENCI Training in Seclusion, Isolation Time-Out (V Based on interview are failed to ensure staff to physical restraint, and 1 of 10 audited staff in #2/Executive Director Finding #1 Review on 2/17/21 of revealed: -Hired 11/3/20; -Terminated 1/3/21; -Employed as direct of State issued identifice	of 2 clients (Client #1). E: 10A NCAC 27G .0604 Equirements for Category A 7) Ind record review, the facility Ill incidents to the LME Intity) responsible for the Exercises are provided Coming aware of the E: 10A NCAC 27E .0107 Exercises to Restrictive Ind record review, the facility Invere trained in alternatives It is a literative Index of the Interview in the facility Invere trained in alternatives In the facility Interview i	V 293			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		MHL036-336	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
FRESH N	EW START		NTINGTON DRIV	E	
	- I	GASTON	IA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 293	Continued From page	25	V 293		
v 250	-Former Staff #4 used driving; -Former Staff #4 was drive anymore because Client #2 in danger; -Was in the van while -Former Staff #4 took Client #1 went inside downstairs; -Former Staff #3 went was left outside of the Interview on 2/17/21 v-Former Staff #4 was drive at all;" -Former Staff #4 took" and the "park with -Went to Former Staff discussed seeing her Multiple attempted int #3 were unsuccessfuleft for Former Staff #2/23/21, 2/24/21, 2/25 Additionally, a text me but was marked at "N Interview on 3/31/21 v #1/Director/Qualified	told she was not allowed to se she put Client #1 and Former Staff #4 drove; Client #1 to her house and the house and was in the Client #1 to her house. into the house but Client #1 house. with Client #2 revealed: a "terrible drivercan't Client #2"to her house her friends smoking;" f #4's house a few times and bedroom and a hookah. erviews with Former Staff I. Phone messages were 3 requesting a call back on 5/21, and 3/22/21. essage was sent on 3/22/21 of Delivered!"	V 255		
	Health Service Regul tomorrow. Interview on 3/31/21 of Director revealed:	ord and notify Division of ation (DHSR) survey staff with Licensee #2/Executive a valid driver's license;			
	-Took a copy of all sta	aff driver's licenses at hire;			

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		_
		MHL036-336	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH NI	EW START		TINGTON DRIV	Æ	
		GASTONIA	A, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 293	Continued From page	e 26	V 293		
	-All staff must provide at hire; -Will re-check her rec	e a copy of a driver's license ord and make sure there not sent to DHSR and will			
	having a valid driver's review after being red 3/31/21 with Licensee Professional #1 and L Director. Interviews on 4/8/21 with Licensee #1/Director/Qualified Licensee #2/Executive exit meeting revealed -When asked if there to present or commer information was provided to prector/Qualified with the procession of the process of the proc	Professional #1 and e Director during the survey			
	-	itutes a recited deficiency.			
	written by Licensee # Professional #1 dated "What immediate active ensure the safety of the Brighter Dayz (Licens V109: Brighter Dayz varequirements of 10A lensuring the competer Professional. Specific	d 4/8/21 revealed: on will the facility take to the consumers in your care? see, Brighter Dayz, LLC) will: will comply with all NCAC 27G .0203 including ency of the Qualified sally, the Qualified ive training by a qualified lays about: dge; ss;			

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DIVISION	n nealth Service Negu	ialion				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			B. WING		R	
		MHL036-336	D. WING		04/16/	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4460 HUN	TINGTON DRIV	/F		
FRESH N	EW START		A, NC 28056	_		
			H, NC 20030			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
IAG	1,2002,110111 0111		IAG	DEFICIENCY)		
V 293	Continued From page	e 27	V 293			
	5. interpersonal skil	lle:				
	6. communication s					
		okiiis, ariu				
	7. clinical skills.	20 1 20 0				
	V110: Brighter Dayz v					
		NCAC 27G .0204 including				
	ensuring the compete					
		ically, the ED (Executive				
		training by a qualified trainer				
	within the 30 days of					
	8. technical knowle	dge;				
	9. cultural awarene	ss;				
	10. analytical skills;					
	11. decision-making;					
	12. interpersonal skil	lls;				
	13. communication s					
	14. clinical skills.	,				
	Specifically QP/ED (C	Qualified				
		ve Director) will ensure that				
		aff provide a copy of a Valid				
		kpired) as part of onboarding				
	,	ensure that as part of				
	HCPR (Health Care F					
	notification, Incident r					
	(Incident Reporting In	•				
	involving allegations					
		_				
	V112: Brighter Dayz v					
		NCAC 27G .0205 including:				
		re provided prior to the				
	establishment and im					
		or service plan, hereafter				
		an," strategies to address the				
		oblem shall be documented				
		nts will not be able to obtain				
	employment unless s	taff is present for the entire				
	workshift.					
	c. Specifically, QP	will ensure that interventions				
		(AWOL(absent without				
	leave)/ELOPEMENT)					
		section of the PCP (person				

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centered plan). QP will document prior histories

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL036-336	B. WING		R 04/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
EDECH NE	W CTADT	4460 HUN	TINGTON DRIV	E		
FKESH N	EW START	GASTONIA	A, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 293	Continued From page	28	V 293			
V 293	and have a meeting which histories are st strategies based on the attend retraining in convince of 10A lensuring all direct car training by qualified to a. Medication disperent and labeling by Medication admirect. Medication admirect. Medication admirect. Medication admirect. Medication educates and labeling by Medication admirect. Medication educates and Medication educates. Medication educates and Medication administry doing so. This responsified back to the Extended to DHSR (Direction of 10A lincluding: d. Ensuring that all reported to DHSR (Direction) and the Lamanagement entity/mas required by the precarolina Department Services) Incident Rethe IRIS and 10A NC timeframes. e. The agency will the first and region incident reporting pannually thereafter. g. The agency will of the agency will the ag	which will serve to establish ill a concern, and develop hose concerns. ED will also ore areas identified. will comply with all NCAC 271g .0209 including re staff have documented rainer in the following topics: ensing: Medication packaging mistration is all and including me staff have documented rainer in the following topics: ensing: Medication packaging mistration is all and including me staff have documented rainer in the following topics: ensing: Medication packaging mistration is all and included in the following me staff will be recently be accurately as a service in the following me staff will be retrained or to hire/return and deconduct at least quarterly	V 293			
	timeframes. e. The agency will If file for inspection for gf. New hires and rein incident reporting pannually thereafter. g. The agency will gelf-audits to ensure the	keep all incident reports on governmental authorities. eturning staff will be retrained prior to hire/return and conduct at least quarterly				

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R
		MHL036-336	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		4460 HIII	ITINGTON DRIV	F	
FRESH N	EW START			L	
	Г		IA, NC 28056		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-/
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG		,	IAG	DEFICIENCY)	
V 293	Continued From page	29	V 293		
	notes to incident repo	arte			
	Specifically, the provi				
		allegations to the HCPR (24			
		y working report, Incidents			
		against staff will be reported			
	in IRIS.				
	V536: Brighter Dayz				
	· · · · · · · · · · · · · · · · · · ·	NCAC 27E .0107 including:			
		choose one Training On			
		ctive Interventions curricula			
		nplete by a qualified trainer			
		27E .0108 . The curriculum			
	will a curriculum appr				
	DMH/IDD/SAS (ment				
	developmental disabi				
	services) on their list	• •			
		ensure all newly hired and			
	•	alid Training On Alternatives			
		ntions certificate on file			
	before working and a				
		conduct at least quarterly			
	self-audits to ensure t				
	V537: Brighter Dayz v				
	requirements of NCA				
		part of October POC (plan of			
	,	e if training for CPI (Crisis			
	Prevention Institute) t	-			
		resulted in a blank page			
	(pg.30 of emailed doo	cuments to DHSR on			
	3/16/21.)				
	• •	o make sure the above			
	happens.				
	Brighter Dayz will:				
		Certified Forensic Health			
	Care Auditor for three				
		y self-audits of the agency to			
	sure compliance with				
	protection) and any s	ubsequent POC. The			

self-audits will be in the record.

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PRINTED: 04/29/2021 FORM APPROVED

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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			B. WING		F	
		MHL036-336	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE ZIP CODE		
FRESH NI	EW START		ITINGTON DRIV	' E		
		GASTON	A, NC 28056			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	INEGOLATORI ORT	EGC IDENTIF TING IN CHWATION)	TAG	DEFICIENCY)	MAIL	57.1.2
				,		
V 293	Continued From page	e 30	V 293			
	0 011 111 111 1	:c :: t D110D1 !!				
		arification from DHSR/other				
	-	uditor regarding treatment				
	strategies of prior behaviors/employment.					
	3. Consult with IRIS	S coordinator for IRIS				
	training.					
	-	nsibility to Executive				
	Director.					
		with newly hired and				
	returning staff about t	his POP and any				
	subsequent POC. The	e initial training will be live or				
	live online.					
	6. Conduct compete	ency-based training with the				
	Qualified Professiona	Il and Executive Director.				
	The initial training will	l be live or live online.				
	b. The agency will r	not place residents in the				
		as all the actions in the				
	POP are fully implem					
	, '					
	Review on 4/13/21 of	the second Plan of				
	Protection written by	Licensee				
	-	Professional #1 dated				
	4/13/21 revealed:					
	"What immediate acti	on will the facility take to				
		he consumers in your care?				
	V109:	•				
	To ensure the health.	safety and welfare of clients				
		e the following actions:				
		rently in our care cannot and				
	will not work without a					
		vorking has been discharged				
		9. QP will also ensure that as				
	part of HCPR notifica					
	· ·	ncident report is filed in IRIS.				
		nply with all requirements of				
		3 including ensuring the				
	competency of the Qu					
		ified Professional will receive				
		trainer by April 30, 2021				
	about:	daa				
	technical knowle	age;				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL036-336	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
EDECH NI	EW/ STADT	4460 HUN	TINGTON DRIV	Æ	
FRESH NI	EW START	GASTONIA	A, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 293	Continued From page	e 31	V 293		
V 293	2. cultural awarene 3. analytical skills; 4. decision-making; 5. interpersonal skil 6. communication s 7. clinical skills. Specifically, QP will a April,18,2021 highligh section. V110: To ensure the health, Brighter Dayz will tak " Client that is curr will not work without a " Client who was v as of December 2019 part of HCPR notifica concerning staff, an li Specifically, ED will a by a qualified trainer l below: 8. technical knowle 9. cultural awarene 10. analytical skills; 11. decision-making; 12. interpersonal skil 13. communication s 14. clinical skills. V112: To ensure the health, Brighter Dayz will tak " The client who w discharged since Dec " Client that is curr will not work without a Brighter Dayz will cor 10A NCAC 27G .0206	ss; clls; clkills; and attend training on PCP's by atting the HOW/SUPPORT safety and welfare of clients the the following actions: rently in our care cannot and adequate supervision. working has been discharged to QP will also ensure that as tion of allegations incident report is filed in IRIS. titend training on the above by 4/30/21 in the areas dge; ss; clls; clkills; and safety and welfare of clients the the following actions: as employed has been tember 2019. Tently in our care cannot and adequate supervision. The property is the property of	V 293		
	establishment and im treatment/habilitation	plementation of the or service plan, hereafter			

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Division of	<u>of Health Service Regu</u>	ılation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
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		MHL036-336			04/1	6/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4460 HUN	TINGTON DRIV	Æ		
FRESH NE	EW START		A, NC 28056			
	OLIMANA DV OT		<u> </u>	DDO///DEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		l
V 293	Continued From nego	- 22	V 293			
V 293	Continued From page	3 32	V 293			1
	referred to as the "pla	an," strategies to address the				1
	client's presenting pro	oblem shall be documented.				1
		nts will not be able to obtain				1
		staff is present for the entire				ı
	work shift.	•				ı
	c. Specifically, QP	will ensure that general				1
		ed to all clients to prevent				1
	(AWOL/ELOPEMENT	T). Any client who had a				1
		in the past 12 months will				1
	have a specific super	vision plan under the				1
		tion of the goal. QP will				1
		ries and have a meeting				1
	which will serve to es	tablish which				1
	histories/behaviors ar	re still a concern, and				1
	develop strategies ba	ased on those concerns.				1
	V118:					1
	To ensure the health,	, safety and welfare of clients				1
	Brighter Dayz will tak	e the following actions:				1
	" As of 3/01/21 the	e staff who was setting up the				1
	Medication Administra	ation Record (MAR) is no				1
	longer doing so. This	s responsibility has been				1
	shifted to the Executiv	ve Director.				1
	Brighter Dayz will cor	mply with all requirements of				1
		09 including ensuring all				1
	direct care staff have	documented training by				1
	qualified trainer in the	following topics:				1
	 Medication disperation 	ensing:				1
	Medication packaging	g and labeling				1
	b. Medication admi	nistration				1
	 c. Medication dispo 	sal				1
	 d. Medication Stora 	age				1
	e. Medication review	W				1
	f. Medication education	ation				1
	g. Medication errors	S				1
	The MAR will be audi	ited weekly by the Executive				
	Director for conforma	nce with standards.				
	V367:					
	To ensure the health,	, safety and welfare of clients				
		e the following actions:				i l

The QP will ensure that in addition to

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		MHL036-336	B. WING		04/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
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V 293	Continued From page	e 33	V 293		
V 293	reporting allegations incidents involving all also be reported in IR Brighter Dayz will cor 10A NCAC 27g .0603 d. Ensuring that all reported to DHSR and by the prevailing NC System (IRIS) within .0604 stipulated times e. The agency will is file for inspection for g.f. The agency will self-audits to ensure including cross walking notes to incident reported to DHSR. Brighter Dayz requirements of 10A IT of ensure the health, Brighter Dayz will tak ED was retrained submitted to DHSR. In folder. Documents page (pg.30 of emails 3/16/21.) Brighter Dayz will ensure the health, Brighter Dayz will tak ED was retrained submitted to DHSR. In folder. Documents page (pg.30 of emails 3/16/21.) Brighter Dayz will ensure the health, Brighter Dayz will ensure the health, Brighter Dayz will tak ED was retrained submitted to DHSR. In folder. Documents page (pg.30 of emails 3/16/21.) Brighter Dayz will ensure the page (pg.30 of emails 3/16/21.) Brighter Dayz will ensure the page (pg.30 of emails 3/16/21.)	to the HCPR involving staff, egations against staff will all S within 72 hours. Inply with all requirements of 1/0.0604 including: Level II and III incidents are doubted the LME/MCO as required DHHS Incident Reporting the IRIS and 10A NCAC 27g frames. It is eep all incident reports on governmental authorities. Conduct at least quarterly this standard is met ang Level I,II, & III progress wits. Will comply with all NCAC 27E .0107 safety and welfare of clients the following actions: If as part of October POC Certificate of CPI training is scanned resulted in a blank and documents to DHSR on the following actions: If all times. Staff without will not be allowed to work. CPI certification monthly. It is part of October POC Certificate of CPI training is each the following actions: If as part of October POC Certificate of CPI training is each part of October POC Certificate of CPI training is each part of October POC Certificate of CPI training is scanned resulted in a blank and documents to DHSR on the following actions: If as part of October POC Certificate of CPI training is scanned resulted in a blank and documents to DHSR on the following actions: If any part of October POC Certificate of CPI training is scanned resulted in a blank and documents to DHSR on the following actions: If any part of October POC Certificate of CPI training is scanned resulted in a blank and documents to DHSR on the following actions:	V 293		
	V537: To ensure the health, Brighter Dayz will tak " ED was retrained submitted to DHSR. in folder. Documents page (pg.30 of emaile 3/16/21.) Brighter Dayz will ensurement CPI training a	safety and welfare of clients e the following actions: d as part of October POC Certificate of CPI training is scanned resulted in a blank ed documents to DHSR on			

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STATE FORM 94HW11 If continuation sheet 34 of 56

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLE	ILED
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V 293	Continued From page	e 34	V 293			
	V293: To ensure the health, Brighter Dayz will take Cross reference respo	cPI certification monthly. safety and welfare of clients the the following actions: onse to V109,110,112,118,				
	happens. Brighter Dayz will: c. Contract with a C Care Auditor for three 1. Conduct quarterl sure compliance with subsequent POC. The record. 2. Obtain distinct of providers/Forensic Austrategies of prior bel 3. Consult with IRIS training, and specificate after submitting HCPI 4. Shift MAR respondirector. 5. Conduct training returning staff about to subsequent POC. The live or online. 6. Conduct compete Qualified Professiona The initial training will documents submitted by auditor. d. The agency will r facility until such time POP are fully impleme e. Agency will reque	Certified Forensic Health amonths to: y self-audits of the agency to this POP and any he self-audits will be in the particulation from DHSR/other auditor regarding treatment the process of the self-audits will be in the particulation from DHSR/other auditor regarding treatment the process of the process				
	•	the third and final Plan of				

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STATE FORM 94HW11 If continuation sheet 35 of 56

MHL036-336 MHL036		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER **TRESH NEW START** **HAGE HUNTINGTON DRIVE GASTONIA.** **LAGE HUNTINGTON GRIVE GASTONIA.	,	o. 001.11.2011011	.52	A. BUILDING:			
NAME OF PROVIDER ON SUPPLIER FRESH NEW START SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG CROSS-REFERENCE DISCIDENCING MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCE DISCIDENCING MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED DISCIDENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED DISCIDENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED DISCIDENCY MUST BE PRECEDED BY FULL DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED DISCIDENCY MUST BE PRECEDED BY FULL DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY DISCIDENCY DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY DISCIDENCY DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY DISCIDENCY DISCIDENCY DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY DISCIDENCY DISCIDENCY DISCIDENCY DISCIDENCY DISCIDENCY TAG CROSS-REFERENCED DISCIDENCY DI			MHI 036-336	B. WING		0,	
Continued From page 35 V293						1 0-	10/2021
CASTONIA, NC 28056 CASTONI	NAME OF P	ROVIDER OR SUPPLIER			, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES ID PRICE REGULT OFFICIENCY REGULT OFFICIENCY OF LESS HERRINGED FOR STATE OF PRICE DEFICIENCY REGULT ORY OF LESS HERRINGED FOR STATE OF PRICE DEFICIENCY	FRESH N	EW START					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 who was working has been discharged as of December 2020. Op 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 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, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our care cannot and " Client that is currently in our		T	GASTON	IA, NC 28056			
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 syll 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
#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? V/109: 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; Appetitically, 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	V 293	Continued From page	e 35	V 293			
" 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.	v 250	Protection written by #1/Director/Qualified 4/15/21 revealed: "What immediate actiensure the safety of t V109: To ensure the health, Brighter Dayz will tak "Client that is currivill not work without a "Client who was vas of December 2020 part of HCPR notifica concerning staff, an I Brighter Dayz will cor 10A NCAC 27G .020: competency of the Qual training by a qualified about: 1. technical knowle 2. cultural awarene 3. analytical skills; 4. decision-making: 5. interpersonal ski 6. communication s 7. clinical skills. Specifically, QP will a April,18,2021 highligh section. V110: To ensure the health, Brighter Dayz will tak "Client that is currivill not work without a "Client who was vas of December 2020 part of HCPR notifical	Licensee Professional #1 dated on will the facility take to the consumers in your care? safety and welfare of clients the the following actions: tently in our care cannot and adequate supervision. Working has been discharged to QP will also ensure that as tion of allegations ancident report is filed in IRIS. Inply with all requirements of an including ensuring the utilitied Professional. If				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUF		
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V 293	Continued From page	e 36	V 293			
V 293	below: 8. technical knowle: 9. cultural awarene: 10. analytical skills; 11. decision-making; 12. interpersonal skill: 13. communication side clinical skills. V112: To ensure the health, Brighter Dayz will take: "The client who will discharged since Decision: "Client that is currival will not work without a Brighter Dayz will contour 10A NCAC 27G .020; a. When services a establishment and imtreatment/habilitation referred to as the "plaction of the plaction of the	dge; ss; dls; ekills; and safety and welfare of clients e the following actions: as employed has been beember 2020. Tently in our care cannot and adequate supervision. Inply with all requirements of including: re provided prior to the plementation of the or service plan, hereafter an," strategies to address the oblem shall be documented. Ints will not be able to obtain taff is present for the entire will ensure that general ed to all clients to prevent T). Any client who had a in the past 12 months will vision plan under the tion of the goal. QP will lies and have a meeting tablish which	V 293			
	Brighter Dayz will take	safety and welfare of clients e the following actions: e staff who was setting up the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 293		ation Record (MAR) is no	V 293		
	longer doing so. This shifted to the Execution	s responsibility has been ve Director.			
		mply with all requirements of 09 including ensuring all			
		documented training by			
	a. medication dispe	• .			
	Medication packaging				
	b. Medication admi				
	c. Medication dispo	osal			
	d. Medication Stora	age			
	e. Medication revie	W			
	f. Medication educ				
	g. Medication errors				
		ited weekly by the Executive			
	Director for conforma	nce with standards.			
		safety and welfare of clients			
		e the following actions:			
		re that in addition to			
	reporting allegations	to the HCPR involving staff,			
	Incidents involving all	legations against staff will			
	also be reported in IR				
		nply with all requirements of			
	10A NCAC 27g .0603				
		Level II and III incidents are			
		d the LME/MCO as required			
		DHHS Incident Reporting			
	.0604 stipulated time	the IRIS and 10A NCAC 27g			
	'	keep all incident reports on			
		governmental authorities.			
		conduct at least quarterly			
	self-audits to ensure	•			
		ng Level I,II, & III progress			
	notes to incident repo				
	V536: Brighter Dayz				
	requirements of 10A	NCAC 27E .0107			
	To ensure the health,	safety and welfare of clients			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 293 Continued From pag	e 38	V 293		
Brighter Dayz will tal " ED was retrained submitted to DHSR. in folder. Document page (pg.30 of email 3/16/21.) Brighter Dayz will encurrent CPI training of the ED will monitor V537: To ensure the health Brighter Dayz will tal " ED was retrained submitted to DHSR. in folder. Document page (pg.30 of email 3/16/21.) Brighter Dayz will encurrent CPI training of the ED will monitor V293: To ensure the health Brighter Dayz will encurrent CPI training of the ED will monitor V293: To ensure the health Brighter Dayz will tal Cross reference resp 132, 367, 536, 537, Describe your plans happens. Brighter Dayz will: a. Contract with a Care Auditor for thre 1. Conduct quarter sure compliance with subsequent POC. Trecord. 2. Obtain distinct of	de the following actions: d as part of October POC Certificate of CPI training is a scanned resulted in a blank and documents to DHSR on sure that all staff have at all times. Staff without will not be allowed to work. CPI certification monthly. , safety and welfare of clients are the following actions: d as part of October POC Certificate of CPI training is a scanned resulted in a blank and documents to DHSR on sure that all staff have at all times. Staff without will not be allowed to work. CPI certification monthly. , safety and welfare of clients are the following actions: conse to V109, 110, 112, 118, 736, 738 to make sure the above Certified Forensic Health agency to conselve to the agency to	V 293		

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PRINTED: 04/29/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FERNIOR CONNECTION		A. BUILDING:		COMPLETED	
	MHL036-336 B. WING			R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
FRESH NI	EW START		TINGTON DRIV A, NC 28056	Æ	
0(1) 15	SLIMMADV ST		1	DDOV/IDED'S DI ANI DE CODDECTIO	N (V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 293	Continued From page	e 39	V 293		
V 293	3. Consult with IRIS training, and specifica after submitting HCPl 4. Shift MAR responding returning staff about the subsequent POC. The live or online. 6. Conduct compete Qualified Professional The initial training will documents submitted by auditor. b. The agency will required in the popular facility until such time POP are fully implemented. Agency will required iscuss implementation. Client #1 was 16 years Depressive Disorder, Disruptive Mood Dysthad a history of repeate leave) with episodes time, overdose, suicid verbal and physical a placed at a local fast month of being admit assessment to determinate to determinate the popular form of the professive of AWOL, self-injurious ideation. No treatment in the popular form of the professive of AWOL, self-injurious ideation.	S coordinator for IRIS ally regarding Incident report R. nsibility to Executive with newly hired and this POP and any e initial training will be live or ency-based training with the all and Executive Director. I be live or live online. Any I to auditor will be signed off ent place residents in the eas all the actions in the ented. est informal conference to ons made by provider." Irs old and diagnosed with Trauma Stressor, and regulation Disorder. She ated AWOL (absent without lasting up to one month at a de attempts, cutting, and litercations. She was job food restaurant within one ted to the facility with no mine the ability to work #2 was 14 years old and Traumatic Stress Disorder en Disorder. He had a history as behaviors and suicidal ant plan strategies were so Client #1 and Client #2's	V 293		
	behaviors.	ot have a valid driver's			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-336	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
FRESH NI	EW START		TINGTON DRIV	E .	
			A, NC 28056		1
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 293	Continued From page	e 40	V 293		
	and Licensee #2/Exe Client #1 and Client # despite the lack of a v Furthermore, Former #4 brought Client #1 a personal homes. Client #1 was prescril her mental health nee treat nightmares and increase suicide risk, disorders and depres treat depression and neurotransmitters, an depression, panic atta lack of documentation 2021 medication adm impossible to determi medications as ordere Furthermore, all staff administration of Clie the first week of Febr	Qualified Professional #1 cutive Director to transport the company vehicle valid driver's license. Staff #3 and Former Staff and Client #2 to their bed medications to address the desta (Prazosin HCl used to insomnia which can Abilify used to treat mood sion, Mirtazapine used to restore the balance of d Zoloft used to treat tacks and anxiety). Due to n on Client #1's February, sinistration record, it was ne if Client #1 received her the dby the physician. responsible for nt #1's medications during uary, 2021 did not report the n associated with Client #1's			
	notifications after an a offering marijuana to was no evidence of L Director having curre	nt training in alternatives to n and seclusion, physical			
	and Licensee #2/Exe provide the clinical ar	Qualified Professional #1 cutive Director did not nd administrative oversight needs of Client #1 and Client ued neglect			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	A. BUILDING:	
				R
MHL036-336		B. WING		04/16/2021
NAME OF PROVIDER OR SUPPLIE	STPEET AF	DDRESS, CITY, STAT	TE ZIR CODE	,
NAME OF TROVIDER OR SOFT EIE		NTINGTON DRIVE	,	
FRESH NEW START		IA, NC 28056	=	
		IA, NC 20030		
PREFIX (EACH DEFI	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 293 Continued From	page 41	V 293		
the Type A1 rule serious neglect.	constitutes a Failure to Correct violation originally cited for An administrative penalty of is imposed for failure to correct			
V 367 27G .0604 Incide	ent Reporting Requirements	V 367		
CATEGORY A A (a) Category A a level II incidents, the provision of It consumer is on the incidents and level to whom the provision of the incidents and level to whom the provision of the incidents are provised are provided are provised a	EQUIREMENTS FOR ND B PROVIDERS and B providers shall report all except deaths, that occur during pollable services or while the the providers premises or level III tel II deaths involving the clients wider rendered any service within the incident to the LME the catchment area where wided within 72 hours of of the incident. The report shall a form provided by the report may be submitted via mail, hile or encrypted electronic ort shall include the following the provider contact and the provide			

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MHL036-336 MHL036-336 B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPLI		
NAME OF PROVIDER OR SUPPLIER **STREET ADDRESS, CITY, STATE, ZIP CODE** **4469 HUNTINGTON DRIVE** GASTONIA, NC. 28056 **PRESH NEW START** **SUMMARY STATEMENT OF DEFICIENCIES** TAG** **SUMMARY STATEMENT OF DEFICIENCIES** (PACH) DEPOCHENCY MUST BE PRECEDED BY PLUL RESULATORY OR USC IDENTIFYING INFORMATION) **V 367* **Continued From page 42** 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 the provider's response to the incident. (d) Category A and B providers ball send a copy of all level III incident from that Pack per provider's response to the incident. (d) Category A and B provider's 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 send a report duarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided. The report shall be submitted on a form provided.			A. BOILDING.		_		
CASTONIA, NC 28056 CASTONIA NC 28056 CAS	MHL036-336			B. WING		1	
CASTONIA, NC 28056 CASTONI	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(A) ID PREFIX ITAM OF DEFICIENCES BY PELL PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MAYS BE PRECEDED BY PELL TAG (FORST-REFERENCE) TO THE APPROPRIATE DEFICIENCY MAYS BE PRECEDED BY PELL TAG (PROSS-REFERENCE) TO THE APPROPRIATE DATE CROSS-REFERENCE) TO THE APPROPRIATE DATE CROSS-REFERENCE TO THE APPROPRIATE DATE DEFICIENCY) V 367 Continued From page 42 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. 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 .3300 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	EDECH N	-\4/ OTA DT	4460 HUNT	INGTON DRIV	E		
PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	FRESH N	EWSIARI	GASTONIA	, NC 28056			
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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
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 10.4 NCAC 26C .0300 and 10.4 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	V 367	Continued From page	: 42	V 367			
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;	V 367	report recipients by the day whenever: (1) the provider information provided information provided information provided information provided information; (2) the provider required on the incided unavailable. (c) Category A and B upon request by the Lobtained regarding the (1) hospital recomposition information; (2) reports by one (3) the provider (4) Category A and B of all level III incident Mental Health, Develor Substance Abuse Serbecoming aware of the providers shall send a incidents involving a composition of the client death within service restraint, the provider death within service restraint, the provider or restraint, the provider or restraint, the provider or restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the cates of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the cates of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint, the provider of the client death within service restraint of the client death within s	the end of the next business Thas reason to believe that In the report may be It or otherwise unreliable; or Tobtains information Interpreted that was previously providers shall submit, IME, other information It incident, including: Incident, including: Incident incident incident It providers shall send a copy It reports to the Division of It incident. Category A It incident. Category A It incident. In cases of It incident as and shall incident as follows: It incident; It incident as incident as an	V 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
					R	
		MHL036-336	B. WING		04	/16/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRESH N	EW START		NTINGTON DRIVE IA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	the possession of a control (5) the total number incidents that occurred (6) a statement been no reportable in incidents have occurred meet any of the criter	client property or property in lient; mber of level II and level III ed; and t indicating that there have cidents whenever no red during the quarter that is as set forth in Paragraphs e and Subparagraphs (1)	V 367			
	failed to report all Lev (local management e catchment area wher within 72 hours of bei incident. The finding: Review on 2/17/21 of Investigations reveale-Undated 24-Hour Ini Personnel Registry (hallegation of neglect marijuana to Client #-Undated 5-Working regarding an allegation Former Staff #3 offeri The 5-Working Day Finitial Report to HCPF	nd record review, the facility yel III incidents to the LME ntity) responsible for the e services are provided coming aware of the s are: facility's Internal ed: tial Report to Health Care HCPR) regarding an for Former Staff #3 offering 1;				
		s (marijuana). ED (Licensee				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
A. BUILDING:					
	MHL036-336 B. WING			R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH NI	EW START		TINGTON DRIV A, NC 28056	Æ	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
V 367	Continued From page	2 44	V 367		
		Professional #1) questioned			
		ring investigation QP & ED			
		to where or when. Client			
	, ,	t told QP & ED several			
		nting what she told her social d was terminated before the			
		is brought to our attention;"			
	_	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:				
		III incident report completed			
		on of Former Staff #3			
	offering marijuana to	Client #1 in January, 2021.			
	Interview on 2/17/21	with Client #1 revealed:			
	-Was offered marijua	na by Former Staff #3.			
		terviews with Former Staff			
		I. Phone messages were 3 requesting a call back on			
	2/23/21, 2/24/21, 2/25				
	Additionally, a text me	essage was sent on 3/22/21			
	but was marked at "N	lot Delivered!"			
	Interview on 2/17/21				
		Professional #1 revealed:			
	_	tion reported by Client #1 to			
	T	ocial Services Social (DSS) er Staff #3 that Former Staff			
	#3 offered marijuana				
		ICPR via the 24-Hour Initial			
	-	g Day Report and an internal			
	investigation was con				
	_	allegation when the local			
	DSS arrived at the fa				
		tioned any concerns to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING			
MHL036-336		B. WING		R 04/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
FRESH NE	EW START		ITINGTON DRIV	E	
			IA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 367	Continued From page	e 45	V 367		
	and Licensee #2/Exe Staff #3 offering marij -Was unable to subst offered marijuana to 0 Former Staff #3 for at -Was not aware that at needed to be completed abuse or neglect. Interview on 3/31/21 #1/Director/Qualified -NC IRIS reports are care staff, Licensee # Professional #1, and Interview on 3/31/21 Director revealed: -Direct care staff alon #1/Director/Qualified responsible for complete staff of the staff and the staff alon #1/Director/Qualified responsible for complete staff and the staff alon #1/Director/Qualified responsible for complete staff and the staff alon #1/Director/Qualified responsible for complete staff and the staff alon #1/Director/Qualified responsible for complete staff alon #1/Director/Qualified responsible staff alon #1/Director/Qualified res	antiate that Former Staff #3 Client #1 but terminated in unrelated matter; a Level III incident report ited regarding allegations of with Licensee Professional #1 revealed: the responsibility of direct itel //Director/Qualified the Licensed Professional. with Licensee #2/Executive g with Licensee			
	exit meeting revealed -Did not report the all (North Carolina Incide System) because in t reveals that all allega HCPR; -Licensee #2/Executive spoke with the LME response -Did not revealed -Did not revealed -Did not revealed -Did not revealed -Did not report -Did not re	Professional #1 and the Director during the survey the egation through NC IRIS tent Response Improvement the NC IRIS handbook it tions are to be reported to the Director revealed she the presentative who handled the presentative who handled the presentation			
	This deficiency consti	tutes a recited deficiency.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		MHL036-336	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
FRESH N	EW START	4460 HU	NTINGTON DRIV	E	
TREOTIN	- VIAIN	GASTON	IIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 367	Continued From page	46	V 367		
	_	es-referenced into 10A ope (V293) for a Failure to			
V 536	27E .0107 Client Right Int.	its - Training on Alt to Rest.	V 536		
	to restrictive intervent (b) Prior to providing disabilities, staff includemployees, students demonstrate compete completing training in other strategies for cr which the likelihood o or injury to a person w property damage is pr (c) Provider agencies	Dement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and eating an environment in fimminent danger of abuse with disabilities or others or revented.			
	compliance and demogathered. (d) The training shall linclude measurable lemeasurable testing (with behavior) on those observations and the service proving annually). (f) Content of the training course.	rritten and by observation of pjectives and measurable passing or failing the training must be completed der periodically (minimum hing that the service aploy must be approved by 0/SAS pursuant to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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				R	
MHL036-336		B. WING		04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE	
EDEOU NE	OTA DT	4460 HUI	NTINGTON DRIV	Œ	
FRESH NE	WSIARI	GASTON	IA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 536	Continued From page	e 47	V 536		
V 536	(g) Staff shall demon following core areas: (1) knowledge people being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with per (5) recognizing organizational factors disabilities; (6) recognizing organizational factors disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in assescalating behavior; (8) communica and de-escalating point and (9) positive behaviors which are used (h) Service providers documentation of initiat least three years. (1) Documenta (A) who particip outcomes (pass/fail); (B) when and work (C) instructor's (2) The Division review/request this documentation of review/request this	and understanding of the and understanding of the and interpreting human the effect of internal and at may affect people with or building positive sons with disabilities; cultural, environmental and at that may affect people with the importance of and n's involvement in making life; essing individual risk for tion strategies for defusing tentially dangerous behavior; havioral supports (providing n disabilities to choose ly oppose or replace unsafe). Is shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name; n of MH/DD/SAS may boumentation at any time.	V 536		
	(i) Instructor Qualification Requirements:	alions and Training			
		all demonstrate competence			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BOILBING.		
	MHL036-336	B. WING		R 04/16/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
EDECH NEW CTART	4460 HUN	TINGTON DRIV	E	
FRESH NEW START	GASTONIA	A, NC 28056		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 536 Continued From page	e 48	V 536		
by scoring 100% on taimed at preventing, need for restrictive inf (2) Trainers sha by scoring a passing instructor training pro (3) The training competency-based, in objectives, measurable observation of behaving measurable methods failing the course. (4) The content service provider plans approved by the Divisit to Subparagraph (i)(5) (5) Acceptable shall include but are reaching a training proved in the course; (C) methods for course; (C) methods for performance; and (D) documentate (6) Trainers shateaching a training proveducing and eliminate interventions at least review by the coach. (7) Trainers shateaching a training at least review in the coach of t	esting in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an gram. y shall be include measurable learning le testing (written and by gror) on those objectives and grow to determine passing or the first of the instructor training the set to employ shall be sion of MH/DD/SAS pursuant grows of this Rule. Instructor training programs and limited to presentation of: inget the adult learner; in teaching content of the grows are all have coached experience or an aimed at preventing, gring the need for restrictive one time, with positive all teach a training program reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain all and refresher instructor	V 330		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		MHL036-336	B. WING		04	R I/16/2021
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FRESH N	EW START	4460 HU	NTINGTON DRIVE			
		GASTON	IIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 536	(A) who partici outcomes (pass/fail) (B) when and (C) instructor's (2) The Division request and review to (k) Qualifications of (1) Coaches sometime requirements as a to (2) Coaches sometime to competence by competence by comparish the course which is competence by competence in the course which is competence by competence by competence in the course which is competence in th	pated in the training and the ;; where attended; and s name. on of MH/DD/SAS may this documentation any time. Coaches: shall meet all preparation ainer. shall teach at least three times being coached. shall demonstrate ipletion of coaching or	V 536			
	failed to ensure staff to restrictive interver audited staff member Director). The finding Review on 3/17/21 of Director's record revel-Hire date 8/1/18; -Training certificate intervention training Intervention program expiration date 10/2; -No additional inform	and record review, the facility f were trained in alternatives ntions affecting 1 of 10 ers (Licensee #2/Executive ngs are: of Licensee #2/Executive realed: for alternatives to restrictive through Nonviolent Crisis in issued 10/23/19 with				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL036-336	B. WING		04/16	/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRESH N	EW START		INGTON DRIV ., NC 28056	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	#1/Director/Qualified and text staff and talk stories straight before and investigators; -Upon telling the truth Department of Social member, she stopped Licensee #1/Director/ Interview on 3/31/21 v Director revealed: -Was trained in Nonviolative and the strained in Nonviolative with meeting revealed and the surface with the su	with Former Staff #4 nvestigations, Licensee Professional #1 would call to them about getting their e speaking with surveyors about the facility to a Services (DSS) staff I getting calls and texts from Qualified Professional #1. with Licensee #2/Executive olent Crisis Intervention. with Licensee Professional #1 and e Director during the survey : ee #2/Executive Director's te for training in Nonviolent s not provided but the	V 536			
V 537	Correct Type A1. 27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	10A NCAC 27E .0108 SECLUSION, PHYSI ISOLATION TIME-OU	CAL RESTRAINT AND				

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PRINTED: 04/29/2021 FORM APPROVED

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DIVISION	n Health Service Negu	ialion					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED	
		MUI DOC DOC	B. WING		R		
		MHL036-336			04/1	6/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
	4460 HUNTINGTON DRIVE						
FRESH NE	EW START	GASTONI	A, NC 28056				
(VA) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO	N	(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE	
				DEFICIENCY)			
V 537	Continued From page	e 51	V 537				
	. •						
		al restraint and isolation					
		loyed only by staff who have					
	been trained and have						
		oper use of and alternatives					
		Facilities shall ensure that					
		ploy and terminate these					
	•	ned and have demonstrated					
	competence at least a						
		direct care to people with					
		atment/habilitation plan					
		terventions, staff including					
	service providers, em						
		olete training in the use of					
		straint and isolation time-out					
		se interventions until the					
	training is completed demonstrated.	and competence is					
		r taking this training is					
		etence by completion of					
		, reducing and eliminating					
	the need for restrictive						
	` ,	be competency-based,					
	include measurable le	•					
	- '	vritten and by observation of					
	,	jectives and measurable					
		e passing or failing the					
	course.						
		training must be completed					
	•	der periodically (minimum					
	annually).						
	(f) Content of the trai						
		ploy must be approved by					
	the Division of MH/DE	•					
	Paragraph (g) of this						
		ng programs shall include,					
	but are not limited to,						
	` '	formation on alternatives to					
	the use of restrictive i						
	(2) guidelines of	on when to intervene	1				

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MHL036-336 MHL036-336 MHL036-336 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID R 04/16/2021	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X				A. BUILDING.		_	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X						1	
FRESH NEW START 4460 HUNTINGTON DRIVE GASTONIA, NC 28056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X			MHL036-336	B. WING		04/10	6/2021
FRESH NEW START GASTONIA, NC 28056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	NAME OF PRO	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GASTONIA, NC 28056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	EDECH NEW	EW STADT	4460 HUN	TINGTON DRIV	E		
(747) 15	FRESH NEW	EW SIAKI	GASTONIA	A, NC 28056			
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	(X5) COMPLETE DATE
V 537 Continued From page 52 V 537	V 537	Continued From page	e 52	V 537			
(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.	(i) continue (i) c	(understanding immir others); (3) emphasis or rights and dignity of a concepts of least resi incremental steps in a concepts of restrictive interventions which in assessment and morp psychological well-be use of restraint through restrictive intervention (6) prohibited proposition (6) prohibited proposition (6) prohibited proposition (6) prohibited proposition (8) documental (9) debriefing simportance and purposition (8) documentation of initiat least three years. (1) Documental (A) who participoutcomes (pass/fail); (B) when and who participoutcomes (pass/fail); (B) when and who participoutcomes (pass/fail); (B) when and who participoutcomes (pass/fail); (C) instructor's (2) The Division review/request this documents: (1) Trainers show scoring 100% on the aimed at preventing, need for restrictive in (2) Trainers show scoring 100% on the teaching the use of since the concepts and the concepts and the concepts and the concepts are concepts and the concepts and the concepts and the concepts are concepts are concepts and the concepts are concepts and the concepts are concepts and concepts are concepts and concepts are concepts are co	on safety and respect for the all persons involved (using trictive interventions and an intervention); or the safe implementation tions; emergency safety include continuous intoring of the physical and eing of the client and the safe ghout the duration of the in; procedures; estrategies, including their ose; and tion methods/procedures. shall maintain ial and refresher training for attion shall include: pated in the training and the where they attended; and name. In of MH/DD/SAS may ocumentation at any time, attion and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. In all demonstrate competence testing in a training program reducing and eliminating program ecclusion, physical restraint	V 551			

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DIVISION	n Health Service Negu	ialion					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED	
			B. WING		R		
		MHL036-336	B. WING		04/16	5/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE			
	4460 HUNTINGTON DRIVE						
FRESH NE	EW START		IA, NC 28056				
		GASTON	IA, NC 20056				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE	
TAG	TREGOE TOTAL OTTE	is in the	TAG	DEFICIENCY)			
V 537	Continued From page	e 53	V 537				
	by accring a passing	arada an taating in an					
		grade on testing in an					
	instructor training pro	_					
	(4) The training						
		nclude measurable learning					
	-	le testing (written and by					
		or) on those objectives and					
	measurable methods	to determine passing or					
	failing the course.						
	(5) The content	t of the instructor training the					
	service provider plans	s to employ shall be					
	approved by the Divis	sion of MH/DD/SAS pursuant					
	to Subparagraph (j)(6	i) of this Rule.					
		instructor training programs					
		be limited to, presentation					
	of:	, p					
		ng the adult learner;					
		r teaching content of the					
	course;	r todorning contont or the					
	•	of trainee performance; and					
		ion procedures.					
	` '	•					
	\ <i>\</i>	all be retrained at least					
	•	trate competence in the use					
		restraint and isolation					
	•	in Paragraph (a) of this					
	Rule.	-11					
		all be currently trained in					
	CPR.						
		all have coached experience					
	•	restrictive interventions at					
	least two times with a	positive review by the					
	coach.						
	(10) Trainers sha	all teach a program on the					
	use of restrictive inter	ventions at least once					
	annually.						
	<u>-</u>	all complete a refresher					
	instructor training at le						
	(k) Service providers						
	• •	al and refresher instructor					
	training for at least the						
		· ,····	1	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BUILDING:			PLETED
		MHL036-336	B. WING		04	R I/16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE	-	
		4460 HU	NTINGTON DRIVE			
FRESH N	EW START	GASTON	IIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	(1) Documenta (A) who particip outcome (pass/fail); (B) when and v (C) instructor's (2) The Division review/request this d (I) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh times, the course whi	tion shall include: vated in the training and the vhere they attended; and name. n of MH/DD/SAS may ocumentation at any time. Coaches: nall meet all preparation niner. nall teach at least three ich is being coached. nall demonstrate oletion of coaching or uction. shall be the same	V 537			
	failed to ensure staff physical restraint, and 1 of 10 audited staff r #2/Executive Director Review on 3/17/21 of Director's record reversiting date 8/1/18; -Training certificate for restraint, and isolation Nonviolent Crisis Interview on 2/23/21 revealed:	nd record review, the facility were trained in seclusion, disolation time-out affecting members (Licensee r). The findings are: Licensee #2/Executive ealed: or seclusion, physical in time-out through ervention program issued ion date 10/23/20.				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		
	MHL036-336	B. WING		R 04/16/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRESH NEW START		INGTON DRIV	E	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 537 Continued From page 55 #1/Director/Qualified Pro and text staff and talk to stories straight before sp and investigators; -Upon telling the truth ab Department of Social Ser member, she stopped ge Licensee #1/Director/Qual Interview on 3/31/21 with Director revealed: -Was trained in Nonvioler Interviews on 4/8/21 with #1/Director/Qualified Pro Licensee #2/Executive D exit meeting revealed: -Not sure why Licensee # most current certificate for Crisis Intervention was not raining was completed in This deficiency constitute This deficiency is cross-r NCAC 27G .1701 Scope Correct Type A1.	ofessional #1 would call them about getting their heaking with surveyors wout the facility to a rvices (DSS) staff etting calls and texts from alified Professional #1. In Licensee #2/Executive and Crisis Intervention. In Licensee fessional #1 and Director during the survey with the survey with the provided but the an October, 2020. The same recited deficiency.	V 537		

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