PRINTED: 09/17/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-857	A. BUILDING: ________ B. WING ________	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH START HOME FOR CHILDREN	**1929 MURRYHILL ROAD GREENSBORO, NC 27403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on 09/09/2021. The complaints were unsubstantiated (Intake #NC00180513 and #NC00180330). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility was not maintained in a safe manner. The findings are: Review on 09/02/2021 of Client #1's record revealed: -Admission date of 03/10/2021 -Diagnoses of Post-Traumatic Stress Disorder (PTSD), Disruptive mood disorder, Attention Deficit/Hyperactivity Disorder (ADHD), Conduct Disorder (Adolescent Onset type) -Age 17 Review on 09/02/2021 of Client #2's record revealed:	V 736	Rule 10A NCAC27G.0303 Location and Exterior Requirements. c. Each Facility and it grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor During Fresh Start's annual survey it was found that bedroom 1 and 2 windows had flat screws in them . And bed room 3 window would not open only 1 two inches. During the visit it was found that the previous QP that was terminated in March had done this. The current QP and AP nor the owner knew about the screws. FS just passed their Fire inspection on 12/6/20. This corrected immediately while the surveyor were there. It would be the responsibility of the QP to check(open) all windows monthly to make sure that they open properly. There are three fire drills done in the facility on a monthly basis. During each during the person doing the drill are to open each window to make sure that it open properly and that their is no repair need. If there is any problems with the windows opening it shall be noted on the drill inspection sheet. The drill inspection form has been modify to add the windows to the fire drill inspection. It is the responsibility of the AP to check the drill inspection sheet for errors and check the windows also.	09/02/21 09/15/21

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director/owner	10/15/21

DHSR - Mental Health
OCT 25 2021
Lic. & Cert. Section

Division of Health Service Regulation

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V 736	Continued From page 1 -Admission date of 06/20/2020 -Diagnoses of Adjustment Disorder, Oppositional Defiant Disorder (ODD) and Moderate Depression -Age 15 Review on 09/02/2021 of Client #4's record revealed: -Admission date of 03/22/2021 -Diagnoses of Major Depressive Disorder, ADHD by history, History of Self Injurious Behaviors (SIB) -Age 15 Observation of the facility on 08/31/2021, from 04:30 PM through 04:43 PM of Client #1, 2 and 3's bedroom windows revealed: -Client #1's bedroom had 1 window. Window had a flat head screw in the frame, which prevented it from opening. -Client #2's bedroom had 2 windows. Window #1 opened partially; approximately an inch and a half and window #2 had a flat head screw in the frame, preventing it from opening. -Client #3's bedroom had 1 window. Window opened partial; approximately 1-2 inches. Interview on 08/31/2021 with Client #1 revealed: -She didn't know about the screws in the other residents' windows. Interview on 08/31/2021 with Client #2 revealed: -She didn't know they (the screws) were there. Interview on 08/31/2021 with Client #3 revealed: -Never noticed the screws in the windows. Interview on 08/31/2021 with Client #4 revealed: -Client #4 resided in Client #1's bedroom when	V 736	On September 15th the current QP and AP presented the new form to the staff and walked them through on how to make sure that all windows are good working conditions. It would be the responsibility of the AP to do periodical checks of windows. After the finding, the QP and AP explained to the residents that it always importtant to let someone know, (LCSW , Ms. Traci, the AP or QP when a staff is doing something to put them in danger. We let them know that they would not get in trouble.	09/02/2021

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FRESH START HOME FOR CHILDREN	1929 MURRYHILL ROAD GREENSBORO, NC 27403

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V 736	Continued From page 2 she (Client#4) first entered the program. She (Client#4) later moved out of the room, where Client#1 now resides. -Noticed the screw in the window around 03/22/2021. -She was told it was done to keep them (clients) from escaping. -Heard that people had broken in and out of the windows before. Interview on 09/03/2021 with Staff #1 revealed: - "The girls mentioned it (screws in the window) to me, but I did not mention to the [Qualified Professional (QP)]." Interview on 08/31/2021 with the Associate Professional (AP) revealed: -"I had no idea screws were in the windows." Interview on 08/31/2021 with the QP revealed: -"I had no idea they (screws) were in the windows. I do not know who could have put them in there. We passed the fire inspection and construction so I'm not sure how long they have been there. Maintenance can come from [nearby city] to remove screws." Review on 08/31/2021 of Plan of Protection, dated 08/31/2021 and handwritten by the QP revealed: -What immediate action will the facility take to ensure the safety of the consumers in your care? "Group Home maintenance will be coming from [nearby city] to come to remove the screws ..." -Describe your plans to make sure the above happens. "Group Home AP and QP will be here at the Group Home to watch the maintenance man remove the screws from the windows ..." The facility client's diagnoses included; Major	V 736		

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NAME OF PROVIDER OR SUPPLIER: **FRESH START HOME FOR CHILDREN**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1929 MURRYHILL ROAD GREENSBORO, NC 27403**

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V 736	Continued From page 3 Depressive Disorder, ADHD by history, History of SIB, Adjustment Disorder, ODD, PTSD, Disruptive Mood Disorder, and Conduct Disorder (Adolescent Onset). Observation of the facility revealed Client # 1 and #2 bedroom windows would not open due to flat head screws in the frame. In addition, Client#3's bedroom window was able to open partially. As a result, immediate evacuation or exit of the facility during a fire or any other emergency through the bedroom windows would have been prevented, which placed all clients at substantial risk of serious harm. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An adminstrative penalty of $500.00 is imposed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain safe water temperatures between 100-116 degrees	V 752	Rule 10A NCAC 27G.0304 Hot Water Temperatures. Temperature immediately that day. Consumer complain that the water is not getting hot enough, but when check the temperatures are right at 116 degrees. Bathroom room remodel when finished on 9/30. The water heater balance pressure valve was adjusted. This stopped the big variance in the different areas. It is the QP responsibility to make sure their is a working them. at the site at all times. The AP is responsible for checking temp varies time during the day to ensure accurate temp readings. Director/Owner had a meeting with the QP and AP and put these additional measure in place for accurate water temp. Director also told the maintenance man do not adjust the water temp on the hot water heater unless the director authorize it.	9/30/21 9/2/21 9/2/21 9/3/21

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V 752	Continued From page 4 Fahrenheit (°F). The findings are: Observation of the facility on 08/31/2021 between approximately 04:20 PM-4:50 PM revealed elevated water temperatures in the following areas: -Bathroom sink 119 °F -Bathroom shower 125 °F -Kitchen sink 128 °F Review on 08/31/2021 of facility temperature log from August 1, 2021- August 31, 2021 revealed: -120 °F on 08/05/2021 -120 °F on 08/11/2021 -121 °F on 08/16/2021 -120 °F on 08/23/2021 -121 °F on 08/25/2021 Interview on 09/03/2021 with Client #1 revealed: -"It's (water) ok, never been burnt. I can adjust it.." Interview on 08/31/2021 with Client #2 revealed: -Never been burned by it (water) -"I just adjust it (water) ..." Interview on 08/31/2021 with Client #3 revealed: -"The water is not too hot for me. It is to my liking ..." -Never been burned and feel the water temperature was appropriate -"If it's too hot, I turn the hot water down ..." Interview on 08/31/2021 with Client #4 revealed: -Always noticed the water was hot and just added more cold water -Never been burned Interview with the Associate Professional (AP) on 09/02/2021 revealed:	V 752		

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V 752	Continued From page 5 -"No one said anything about water too hot. We do a daily water temp check and it was never that high (128)." Interviews with the Qualified Professional (QP) on 08/31/2021, 09/1/2021, and 09/02/2021 revealed: -"We haven't heard anything about the water being too hot. We do a water temp check daily. I didn't realize it was that high (128). The gauge is in the basement and staff have access to it. I don't know if someone messed with it or not. Staff have access to the basement. I don't recall it being that high and the girls have not said anything." -"Water temperature reader broke yesterday (08/30/2021) ..."	V 752		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA CERTIFIED MAIL

September 21, 2021

Ms. Traci Martin
JMJ Enterprise, LLC
2020 Textile Drive
Greensboro, NC 27405

RE: Type A2 Administrative Penalty
Fresh Start Home for Children, 1929 Murryhill Road, Greensboro NC 27403
MHL # 041-857
E-mail Address: tmartin@jmjenterprise.net

Dear Ms. Traci Martin:

Based on the findings of this agency from a survey completed on September 9, 2021, we find that JMJ Enterprise, LLC has operated Fresh Start Home For Children in violation of North Carolina General Statute (N.C.G.S.) § 122C, Article 2, the licensing rules for Mental Health, Developmental Disabilities, and Substance Abuse Services issues. After a review of the findings, this agency is taking the following action:

Administrative Penalty – Pursuant to N.C.G.S. § 122C-24.1, the Division of Health Service Regulation, Department of Health and Human Services (DHHS), is hereby assessing a Type A2 administrative penalty of $500.00 against JMJ Enterprise, LLC for violation of 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Payment of the penalty is to be made to the Division of Health Service Regulation and mailed to the Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, North Carolina 27699-2718. If the penalty is not paid within sixty (60) days of this notification, a 10% penalty plus accrued interest will be added to the initial penalty amount as per N.C.G.S. § 147-86.23. In addition, the Department has the right to initiate judicial actions to recover the amount of the administrative penalty. The facts upon which the administrative penalty is based and the statutes and rules which were violated are set out in the attached Statement of Deficiencies which are incorporated by reference as though fully set out herein.

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within thirty (30) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of

Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

North Carolina General Statute § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such actions is Ms. Lisa G. Corbett, General Counsel. This person may receive service of process by mail at the following address:

Ms. Lisa G. Corbett, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR at 336-861-7342 within thirty (30) days from the date of this letter. Please note that the use of informal procedures does not extend the 30 days allowed to file for a contested case hearing as explained above.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Robin Sulfridge, Western Branch Manager at 336-861-7342.

Sincerely,
Michiele Elliott

Michiele Elliott, Acting Chief
Mental Health Licensure & Certification Section

Cc: dhsrreports@dhhs.nc.gov, DMH/DD/SAS
Medicaid.dhsr.notice@dhhs.nc.gov, NC Medicaid
accreditationNotifications@nctracks.com, NC Medicaid Fiscal Agent
qmemail@cardinalinnovations.org
QM@partnersbhm.org
_DHSR_Letters@sandhillscenter.org
Heather Skeens, Director, Guilford County DSS
Candice W. Moore, NCDPS (all child residential facilities with juvenile justice involvement)
Pam Pridgen, Administrative Supervisor

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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MARK PAYNE • Director, Division of Health Service Regulation

September 21, 2021

Ms. Traci Martin
JMJ Enterprise, LLC
2020 Textile Drive
Greensboro, NC 27405

Re: Annual/Compliant/Follow Up Survey completed September 9, 2021
Fresh Start Home for Children, 1929 Murryhill Road, Greensboro NC 27403
MHL # 041-857
E-mail Address: tmartin@jmjenterprise.net
Intake #NC00180330 and #NC00180513

Dear Ms. Traci Martin:

Thank you for the cooperation and courtesy extended during the Annual/Compliant/Follow Up Survey completed September 9, 2021. The complaints were unsubstantiated.

As a result of the follow up survey, it was determined that the deficiency is now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

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

Type of Deficiencies Found

- Type A2 rule violation was cited for 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (V736).
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A2 violations must be ***corrected*** within 23 days from the exit date of the survey, which is October 2, 2021. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A2 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 against JMJ Enterprise, LLC for each day the deficiency remains out of compliance.
- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is November 8, 2021.

What to include in the Plan of Correction

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

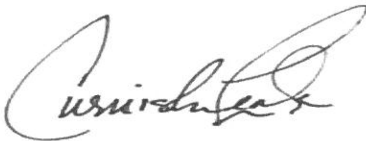
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call If we can be of further assistance, please call Barbara Perdue at (336) 861-6283.

Sincerely,



Curnisha L. Leak
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
QM@partnersbhm.org
_DHSR_Letters@sandhillscenter.org

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL041-857 (Y1)	A. Building B. Wing (Y2)	9/9/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESH START HOME FOR CHILDREN	1929 MURRYHILL ROAD GREENSBORO, NC 27403

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0296 Reg. # 27G .1704 LSC	Correction Completed 09/09/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Curnisha L. Leak	DATE 09/20/2021
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/21/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO