STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
							R
		MHL026-889		B. WING		03/	14/2022
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
FRESH S	START RESIDENTIAL	FACILITY, INC #3		IBARTON RO VILLE, NC 2			
(X4) ID		TEMENT OF DEFICIENCIE	S	ID ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		MUST BE PRECEDED BY SC IDENTIFYING INFORMA		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMENT	TS .		V 000			
		w up survey was cor Deficiencies were c					
	category: 10A NCA	sed for the following C 27G .5600C Supe h Developmental Dis	rvised				
		sed for 4 and current urvey sample consist clients.					
V 114	27G .0207 Emerge	ncy Plans and Suppl	ies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro- posted in the facility (c) Fire and disaste shall be held at least repeated for each se	n for each facility an plan shall be developed the appropriate located and routes and routes and routes and routes and router and all thift. Drills shall be coat simulate fire emerall have basic first aid	d ped and cal all staff shall be acility be onducted gencies.				
	facility failed to ensi held quarterly and r findings are:	et as evidenced by: view and interviews, ure fire and disaster epeated on each shi	drills were ft. The				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL026-889		B. WING			R 14/2022
FRESH START RESIDENTIAL FACILITY INC #3 2639 DUN			DRESS, CITY, S IBARTON RO VILLE, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMA'	-ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 114	revealed: - No fire drills docur and 2nd quarter of 2 - No disaster drills of during for the 1st quarter of 2 - No disaster drill do the 2nd quarter of 2 - Interview on 03/10/2 - 1st shift is from 4 - 3rd shift is from 4 - 3rd shift is from 8a - 2nd shift is from 4a - 3rd shift is from 1a - She understood the should be complete each shift.	mented on 2nd shift for 2021. documented for 2nd suarter of 2021. documented for 1st shift for 2021. documented for 1st shift fo	shift ift during at times. essional ills ated on	V 114			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shad clients only when a client's physician. (3) Medications, inclienting administered only by		s shall ritten rescribe od by the ill be or by	V 118			

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STATE FORM 6899 U07C11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL026-889	B. WING		R 03/1	₹ 4/2022
	PROVIDER OR SUPPLIER	FACILITY INC #3 2639 DUM	DRESS, CITY, S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for (D) date and time th (E) name or initials drug. (5) Client requests to checks shall be recorded.	legally qualified person and e and administer medications. ministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The	V 118			
	facility failed to keep	et as evidenced by: views and interviews, the o the MARs current affecting ed clients (#1, #2 and #3). The				
	revealed: - 47 year old female - Admission date of - Diagnoses of Mild Developmental Disa					

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STATE FORM 6899 U07C11 If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION		SURVEY PLETED
				A. BUILDING.			R
		MHL026-889		B. WING			14/2022
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRESH S	START RESIDENTIAL	FACILITY, INC #3		IBARTON RO			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
V 118	Continued From page 3			V 118			
	Review on 03/10/23 signed medication - 11/05/21 - Benztro Disease symptoms one tablet twice da - 10/25/21 - Buspar tablet three times of - 02/14/22 - Olanza take one tablet twice - 12/21/21 - Zolpida and 1/2 tablets ever	2 and 03/14/22 of clies orders revealed: opine (treats Parkinson) 0.5 milligrams (mg) illy. If (anti anxiety) 15mg laily. If apine (antipsychotic) one daily. If (sleep aid) 10mg fry day. If 2 of client #1's January ovealed the following 2 thru 01/31/22.	on's) - take - take one 10mg - - take 1				
	- Zoldipem - 03/01/22 thru 03/09/22 Benztropine - 03/05/22 at 8pm Buspar - 03/05/22 and 03/09/22 at 8pm Olanzapine - 03/05/22 and 03/09/22 at 8pm. Interview on 03/10/22 client #1 stated she received her medications daily as ordered.						
	revealed: - 37 year old female - Admission date of - Diagnoses of Imp Severe IDD and Int Review on 03/10/20 signed medication	f 07/31/17. Julsive Control Disord termittent Explosive I 2 and 03/14/22 of clie	ler, Disorder. ent #2's				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ILTIPLE CONSTRUCTION DING:	(X3) DATE COMF	SURVEY PLETED
			A. BUIL	DING.		₹
		MHL026-889	B. WING	G		14/2022
NAME OF	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, O	CITY, STATE, ZIP CODE		
FRESH S	START RESIDENTIAL	FACILITY, INC #3	DUMBARTO ETTEVILLE, I			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	EIX (EACH CORRECTIVE A	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE DATE
V 118	Continued From pa	ige 4	V 118			
	- 11/24/21 - Previde and tooth decay) us - 01/26/22 - Quetial take 4 tablets total - 02/04/22 - Topirar seizures) - take 3 ta	pine (antipsychotic) 200m daily. nate (Topamax) (treats	g -			
	MAR revealed the f - Divalproex - 03/09/ - Prevident - 03/09/ - Quetiapine - 03/09/ - Topiramate - 03/0	following blanks: 9/22 at 8pm. /22 at 8pm. 9/22 at 8pm.				
	Interview on 03/10/22 client #2 stated she received her medications daily as ordered.					
	revealed: - 27 year old female - Admission date of - Diagnoses of Mod					
	signed physician or - 11/23/21 - Divalpr - 04/05/21 - Ferrous daily and Loratadin once daily. - 11/22/21 - Perphe take twice daily.	2 and 03/14/22 of client #3 ders revealed: oex 750mg - once daily. s Sulfate (iron) 325mg - or e (treats allergies) 10mg - enazine (antipsychotic) 16r	nce ng -			
	revealed the following - Divalproex - 03/05		2			

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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	
		MUU OOC OOO	B. WING			R
		MHL026-889	<u> </u>		03/	14/2022
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY, DUMBARTON R			
FRESH	START RESIDENTIAL	EΔCH HY INC #3	TTEVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118			V 118			
	- Loratadine - 03/05 - Quetiapine - 03/05					
		22 client #3 stated she ations daily as ordered.				
	stated: - All clients had recordered She checked the label of the she would ensure		al			

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