Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL026-889 03/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2639 DUMBARTON ROAD FRESH START RESIDENTIAL FACILITY, INC #3 **FAYETTEVILLE, NC 28306** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on March 7, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients. V 118 27G .0209 (C) Medication Requirements V 118 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of RECEIVED all drugs administered to each client must be kept current. Medications administered shall be APR 1 - 2024 recorded immediately after administration. The MAR is to include the following: **DHSR-MH Licensure Sect** (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.

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

Montay Muniard Director Owner

3/26/2024

STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		MHL026-889	B. WING		03/07	7/2024				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE						
FRESH START RESIDENTIAL FACILITY, INC #3 2639 DUMBARTON ROAD										
FAYETTEVILLE, NC 28306										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE					
V 118	(5) Client requests checks shall be rec	ge 1 for medication changes or orded and kept with the MAR appointment or consultation	V 118							
	This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 2 of 3 audited clients (#1 and #2). The findings are:			V118 QP and House Manager reviewed a medical records and confirmed that proper orders were in place and all medications were received and ente correctly in the Therap system. All	the	03/23/24				
	Finding #1 Review on 3/7/24 of client #1's record revealed: -29 year old femaleAdmitted on 8/13/08Diagnoses of Mood Disorder, Bipolar Disorder, Mild Intellectual Disability and Learning Disorder. Review on 3/7/24 of client #1's signed physician order dated 1/12/24 revealed: -Debrox 6.5% Ear Drops, 5 drops into affected ear twice daily.			medications administered during the previous week until current date (03 confirmed as administered and doct in the Therap system. House Manager will review physicial service orders immediately following consumers' appointments. House M will follow up with prescribing physiciany questions or concerns regarding medications. House Manager will follow the pharmacy immediately to confir delivery of medications.	/23) were imented in anager ians low up m	ongoing				
	Review on 3/7/24 of 12/1/24 - 3/7/24 reve-Debrox 6.5% Ear D Interview on 3/7/24 o-She received her m	rops was started on 2/6/24.		QP will review Medication Administration profiles on a weekly basis to confirm medications are administered and documented immediately following administration. QP will immediately rany deficiencies to the House Manag Director. The results of the monitoring activities be reported to the quality assurance committee on a quarterly basis by the Director.	eport ger and es will	ongoing				

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(X3) DATE SURVEY

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	S:	COMPLETED		
		MHL026-889	B. WING		R 03/07/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2639 DUMBARTON ROAD FAYETTEVILLE, NC 28306							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	OULD BE COMPLETE		
V 118	-Admitted on 7/9/10 -Diagnoses of Sever Disabilities, Cerebra and Allergy to Insection, inject substitution outer thigh. (allergic Observation on 3/7/2 pm of client #2's me-Epinephrine Inject to 10/2/22. The expirate 8/2023. Interview on 3/7/24 of She received her moderate in the content with the content with the poly of the proof of the pharmacy content with the poly of the	re Intellectual Developmental al Palsy, Allergy to Seafood to Bites. hysician order for Epinephrine cutaneously as directed into reaction) 24 between 2:00 pm - 2:30 edications revealed: was last dispensed on cion on the medication was client #2's stated: edications twice a day. the Group Home Manager by the doctor on 1/12/24. Inform the staff who attended ent he had prescribed the rops. acted her and asked about escription. In a follow up appointment for tion was prescribed. It is refill for client #2's Intellectual Developmental a refill for client #2's Intellectual Developmental a recited deficiency ed within 30 days.	V 118				
V 736	27G .0303(c) Facility 10A NCAC 27G .030 EXTERIOR REQUIR	- NO 1984 1 C CO CONT CARE A TRACTARIO AND	V 736				

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

STATE FORM

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING MHL026-889 03/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2639 DUMBARTON ROAD** FRESH START RESIDENTIAL FACILITY, INC #3 **FAYETTEVILLE, NC 28306** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 736 Continued From page 3 V 736 (c) Each facility and its grounds shall be V736 maintained in a safe, clean, attractive and orderly House Manager will do a weekly walk through manner and shall be kept free from offensive ongoing of the home to verify any deficiencies and odor. report to Director. House Manager will utilize home inspection form and report to Director This Rule is not met as evidenced by: monthly to ensure deficiency does not Based on observation and interview, the facility reoccur. was not maintained in a safe, clean, attractive Director will create service orders needed and and orderly manner. The findings are: ongoing confirm all deficiencies have been corrected. Observation on 3/7/24 between 9:45am -Director will do a monthly walk through of the 10:30am during a tour of the facility revealed: ongoing home to identify additional deficiencies in the -The light fixture cover on the wall light above the home and arrange follow up repairs. kitchen sink was missing. -The light fixture cover in the laundry area was The following deficiencies were corrected: 03/23/24 Light fixture cover on the wall light above the missina. kitchen sink has been replaced. The downstairs bathroom had paint peeling Downstairs bathroom has been repainted around the sink. around the sink. -The downstairs bedroom's smoke detector Batteries have been replaced in the smoke chirped about every 60 seconds. detector in the downstairs bedroom. Interview on 3/7/24 the Group Home Manager stated: -The light fixture above the kitchen sink did not work and needed to be removed. -She had not noticed the smoke detector chirping. -She would ensure maintenance was completed.

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