STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411011	A. BUILDING: _____ B. WING _____	R 06/09/2025

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FLYING START CREATIVE EXPRESSIONS, INC	1204 STERNLY WAY HIGH POINT, NC 27260

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 6/9/25. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified	V 367		

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V 367	Continued From page 1	V 367		

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

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V 367	Continued From page 2 definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to submit Level II incident report to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 6/5/25 of the Internal Incident report dated 3/16/25 revealed: - Staff reporting: staff #1 - "[Client #1] started off disrespecting staff, not listening told her repeatedly to get on task would not listen. [Client #1] went to do kitchen chores reached in cabinet grabbed knife aimed it at staff stating 'I'm going to leave your going to let me or I'm going to cut you' went out garage with knifed aimed at [staff #1] then took off running away called 911 told them I have a runaway [client #1] she is armed with a knife threatening to harm	V 367		

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V 367	Continued From page 3 staff and herself. Police found her, she cut herself. Was taken to the hospital." Review on 6/5/25 of the Incident Response Improvement System (IRIS) revealed: - There was no report of the 3/16/25 incident. Interview on 6/6/26 with the Qualified Professional revealed: - She did an internal incident report for the 3/16/25 incident. - "I did not do an IRIS report." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
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 6/2/25 of the North Carolina Residential Building Code Section 310.2.1 revealed: -"Emergency Egress-Every sleeping room shall have at least one operable window or emergency door approved for emergency egress. The units must be operable without the use of key or tool to a full clear opening. If a window is provided, the sill height may not be more than 44" above the	V 736		

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V 736	Continued From page 4	V 736		

floor. These must provide a clear opening of 4 square feet. The minimum height shall be 22 inches and minimum width is 20 inches (1996 Building Code). (For buildings built under the previous Residential Building Code the requirements allowed for a sill height of 48" and an opening of 432 square inches in an area with a minim dimension of 16."

Observation on 6/5/25 at approximately 3:43 pm of client #1's bedroom revealed:
- There was only one window in the second-story bedroom.
- The bedroom window was designed to slide open from right to left.
- The bedroom window would not slide open because there was a metal lock on the bottom of the window.
- The AFL (Alternative Family Living) Provider used a key to unlock the window lock then opened the window.

Interviews on 6/5/25 and 6/6/26 with client #1 revealed:
- She did not know why her window had a lock on it.
- She later indicated her window had a lock on it, because she had told her AFL Provider she had wanted to jump out of the window.
- She had never tried to open her window.

Interviews on 6/5/25 and 6/6/25 with the AFL Provider revealed:
- She and the staff had keys to the lock on client #1's window.
- The lock was on client #1's window to prevent her from jumping out of the window.
- Client #1 had threatened to jump out of the window in the past.
- The Qualified Professional (QP) was supposed

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V 736	Continued From page 5	V 736		

to complete rights restriction paperwork for client #1 to have a lock on her window.
- The QP never provided her with the rights restriction paperwork.

Interview on 6/5/25 with staff #1 revealed:
- She had a key to the lock on client #1's bedroom window but she did not have the key currently on her.
- The lock on client #1's bedroom window was installed in November 2024 after client #1 threatened to jump out of the window.

Interviews on 6/5/25 and 6/6/26 with the QP revealed:
- She knew that client #1 had a lock on her window.
- The lock was installed on client #1's bedroom window because client #1 had threatened to jump out of the window.
- The lock was installed on client #1's bedroom window "sometime in November (2024)."
- "We sent everything onto HRC (Human Rights Committee). We wrote it up in our HRC."
- "I never got HCR approval for the lock on [client #1's] window when she (the AFL Provider) did it (put the lock on client #1's window) in November (2024)."
- "I dropped the ball. I take full responsibility for the lock."

Review on 6/9/25 of the Plan of Protection dated 6/9/25 written by the Program Manager revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? The AFL provider will remove the lock off the window of [client #1] HRC has approved to put window alarm on the window. Effective 6/5/25.
Describe your plans to make sure the above happens.

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V 736	Continued From page 6 The QP will come to visit the home (facility) to ensure the lock is removed. The QP will be consistent to monitor the window while completing MONTHLY CHECKS. Responsible Staff: QP, AFL Provider, and Program Manager." This facility served clients with diagnoses of Moderate Intellectual Disabilities; Autism Spectrum Disorder; Impulse Control Disorder; Unspecified Disruptive Conduct Disorder; Bipolar Affective Disorder; Attention Deficit Hyperactivity Disorder; Traumatic Brain Injury; and Major Depressive Disorder. Client #1's upstairs bedroom had one window with a lock on it that could only be unlocked with a key the staff members kept. This prevented egress from the client's bedroom window in case of a fire or disaster emergency. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 736		