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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLYING START CREATIVE EXPRESSIONS, INC	1204 STERNLY WAY HIGH POINT, NC 27260

(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 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	RECEIVED JUL 10 2025 DHSR-MH Licensure Sect	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Patrina Hodges (X6) DATE 7/7/25

Date: 7/7/2025

Facility Name: Number Flying Start Creative Expressions, INC. MHL: 041 – 1011

Exit Date: 6/9/2025

V 367. 27G.0604

When incident reports are sent in by staff the QP or Program Manager will complete the IRIS Report as soon as it is received. The Program Manager Will Review the report and confirm the reports has been properly reported to IRIS. The IRIS Report for [redacted] for an incident on 3/16/2025 was completed by the QP on 6/26/2025. The QP completed it, there was a problem submitting. The QP/ Program Manager emailed the IRIS Report to IRIS@partnersbhm.org. A copy of the IRIS Report and email that was sent to IRIS@partnersbhm.org will be included.

Effective: 6/26/2025

V736

The lock was removed by the AFL Provider effective: 6/5/2025 to ensure the lock was removed the QP will consistently monitor the window while completing MONTHLY MONITOR CHECK.

Effective: 6/5/2025

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Rule Violation and Client/Staff Identifier List

Facility Name: Flying Start Creative Expressions, Inc. MHL Number: 041-1011
Exit Date: 6/9/25 Surveyor(s): [redacted]

EXIT PARTICIPANTS: [redacted] **Program Manager**

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0604 Incident Reporting Requirements (V367)/**recite**

When incident reports are sent in staff has been advised to send reports to QP as well as the Program Manager. The QP will complete the IRIS Report as soon as it is received. The Program Manager Will Review the report and confirm the reports has been properly reported to IRIS.

Responsible Party: QP and Program Manager
Correction Date: 7/11/2025

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0303 Location and Exterior Requirements (V736)/**Type A**

The AFL Provider will remove the lock off the window of M[redacted]RC has approved to put window alarm on the window.

Effective: 6/5/2025

The QP will come to visit the home to ensure the lock is removed. The QP will be consistent to monitor the window while completing MONTHLY CHECK.

Responsible Staff: QP, AFL Provider, Program Manager

Client & Staff Identifier List
(Indicate staff title or number beside each name)

Client # 1 MP
Client # 2 KC
Client # 3 SN

Staff #1 BS DSP
Staff #2 BM Back – up staff (To ensure all documentation is in file). Consult H.R.

CITATION LEVEL: Number of days from survey exit for citation correction
Standard = 60 days **Recite** – standard = 30 days **Type A** = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date