		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
MHL092-931		B. WING		R 10/24/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	DRESS, CITY, STA	re, zip code	
			TE PINE DRIVE		
BRIGHTSI	DE HOMES INC		, NC 27612		
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	
V 000	INITIAL COMMENTS		∨ 000		
		up survey was completed . A deficiency was cited.			
		ed for the following service 27G .5600A Supervised Mental Illness.			
V 114	27G .0207 Emergen	cy Plans and Supplies	V 114		
	AND SUPPLIES (a) A written fire plan area-wide disaster p shall be approved by authority. (b) The plan shall be and evacuation proc posted in the facility. (c) Fire and disaster shall be held at least repeated for each shunder conditions that	lan shall be developed and the appropriate local made available to all staff edures and routes shall be		V 114 As of 10/25/18 the stabeen in-serviced on fire and disaster drill requirements a how and when to conduct f disaster drills. Fire drills will conducted on all shifts at lequarterly. This means at leavery shift during the quart schedule will require a disable as well. The administrator of the review compliance monthly initial the documentation of month.	and on ire and be ast ast 1 for er. This ster drill will
	failed to conduct fire on each shift. The find Review on 10/22/18 for the past 12 mont conducted in the modulated in the modu	view and interview, the facility and disaster drills quarterly indings are: of the fire and disaster drills ths revealed all drills were		DHSR-Men NOV 0 Lic. & Cer	6 2018

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

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL092-931 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4133 WHITE PINE DRIVE **BRIGHTSIDE HOMES INC** RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 114 V 114 Continued From page 1 During an interview on 10/24/18, the administrator reported she had never received paperwork from the previous survey and hadn't known she had been cited for this last year. She stated she would ensure the drills would be conducted on each shift. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

Division of Health Service Regulation