Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
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		MHL036-331	B. WING		06/23/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BRIGHTE	R DAYZ LLC	837 LYNHA					
GASTONIA, NC 28052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION							
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETE	
V 000	INITIAL COMMENTS		V 000				
	2020. The complaint	as completed on June 23, s were unsubstantiated) and 166326). A deficiency					
		d for the following service 27G .1700 Residential re for Children or					
V 367	27G .0604 Incident R	eporting Requirements	V 367				
	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 or responding.						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX TAG Continued From page 1 (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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
BRIGHTER DAYZ LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 1 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required 837 LYNHAVEN DRIVE GASTONIA, NC 28052 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 367 V 367		MHL036-331	B. WING		06/23/2020	
CASTONIA, NC 28052 CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE V 367 Continued From page 1 V 367 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required CACH CORRECTIVE ACTION SHOULD BE (EACH C	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 1 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (B) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	BRIGHTER DAYZ LLC					
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required	PREFIX (EACH DEFICIENT	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
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 nicident 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. Category A providers shall send a copy of use of seclusion of restraint, the provider shall report the death immediately, as required by 10A NCAC 2EC 0.0300 and 10A NCAC 2TE. 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 definition of a level II or level II in cident;	(b) Category A and missing or incomplet shall submit an upda report recipients by the day whenever: (1) the provided information provided erroneous, misleading (2) the provided required on the incide unavailable. (c) Category A and upon request by the obtained regarding the (1) hospital resinformation; (2) reports by (3) the provided (d) Category A and of all level III incident Mental Health, Deversubstance Abuse See becoming aware of the providers shall send incidents involving an Health Service Regulation becoming aware of the client death within second restraint, the provimmediately, as required. O300 and 10A NCA (e) Category A and report quarterly to the catchment area when The report shall be seen by the Secretary via include summary infinical in medication.	B providers shall explain any te information. The provider sted report to all required the end of the next business or has reason to believe that in the report may be ag or otherwise unreliable; or er obtains information ent form that was previously. B providers shall submit, LME, other information the incident, including: cords including confidential other authorities; and er's response to the incident. B providers shall send a copy of the reports to the Division of lopmental Disabilities and ervices within 72 hours of the incident. Category A a copy of all level III client death to the Division of lation within 72 hours of the incident. In cases of the incident. In cases of the incident. In cases of the incident of lation within 72 hours of the incident. In cases of the incident of lation within 72 hours of the incident of lation within 72 hours of the incident. In cases of the incident of lation within 72 hours of the incident of lation within 72 hours of the incident. In cases of the incident of lation within 72 hours of the incident. In cases of the incident of lation within 72 hours of lation within 72 hours of lation of lation within 72 hours of lation within 73	V 367	DEL IOIENOT)		

Division of Health Service Regulation

STATE FORM 6899 JISK11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING 06/23/2			6/23/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	the definition of a leve (3) searches of (4) seizures of the possession of a c (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter	aterventions that do not meet el II or level III incident; a client or his living area; client property or property in lient; mber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that is as set forth in Paragraphs e and Subparagraphs (1)	V 367			
	did not report all Leve management entity re area where services a of becoming aware of are: Review on 6/15/20 - 6 #3's record revealed: -Admitted 4/24/20; -Discharged 6/4/20; -Diagnosed with Majo Attention Deficit Hype	as evidenced by: and record review, the facility all II incidents to the local asponsible for the catchment are provided within 72 hours the incident. The findings all 123/20 of Discharged Client are Disruptive Disorder, aractivity Disorder, and				
		the facility's Incident t dated 4/28/20 involving				

Division of Health Service Regulation

STATE FORM 6899 JISK11 If continuation sheet 3 of 4

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL036-331	B. WING		06	/23/2020	
	ROVIDER OR SUPPLIER	837 LYN	DDRESS, CITY, STATE HAVEN DRIVE NIA, NC 28052	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 367	resulting in police inv Interview on 6/23/20 -Believed that the inc Discharged Client #3 4/28/20 was started in Response Improvement	with the Licensee revealed: ident report involving 's episode of aggression on in the North Carolina Incident ent System was created but operly. Would ensure	V 367				

Division of Health Service Regulation