	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RIGHTE	R DAYZ LLC		HAVEN DRIVE			
		GASTON	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
	A complaint survey was completed on September 29, 2020. The complaint was unsubstantiated (Intake #NC168063). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.					
	sister facility is identi Clients are identified and a numerical iden with only a numerical interviews, it was est	ntified in this report. The fied as Sister Facility A. using the letter of the facility tifier. All staff are referred to I identifier. Through multiple ablished that staff were				
	shared between facil	ities.				
	including the exit constaff continued to be Health Service Regueventually identified. made to Licensee #1 Professional #1 and Director for a complestaff at the onset of the were made via phone approximately 10:30a licensees on 8/10/20 10:17am. A staff list fax on 8/12/20 after 5	Licensee #2/Executive te list of current and former he survey. The requests				
	During survey, it was current and former st reported by either lice These staff were disc names of these staff	a discovered that multiple taff were not voluntarily ensee to the DHSR surveyor. cussed in interviews, but the members were not identified . Email correspondence sent				

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

TITLE

(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		— 09/29/20		
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE			
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE	
V 000	Continued From page	e 1	V 000				
	they did not know the 8/27/20, DHSR non-of from previous survey Staff #11/Former Clie Former Staff #12 wer was identified as Staf occurred when Licens revealed in an email Staff #6 was on-site a 7/31/20, 8/1/20, and 3 Department of Social Facility A and that it w the safety plan for Sis Licensee #2/Executiv was only working for training. An additiona identified during exit. Director revealed she needed to be identified	d. The licensees reported e individuals in question. On disclosed documentation s was reviewed. Former ent #A2's Grandmother and re identified. A female staff ff #6. This identification see #2/Executive Director on 9/3/20 at 12:31pm that at Sister Facility A on					
V 108	 (g) Employee training provided and, at a min following: (1) general organization (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet for the second sec	2 PERSONNEL tion shall be documented. g programs shall be nimum, shall consist of the ational orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation	V 108				

Division of Health Service Re STATE FORM

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If continuation sheet 2 of 109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MUL 020 004			00/00/0000	
	OVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE		09	/29/2020
RIGHTER	DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
	5602(b) of this Subcl member shall be ava times when a client is member shall be train including seizure man to provide cardiopulm trained in the Heimlic techniques such as th the American Heart A equivalence for reliev (i) The governing boo implement policies an reporting, investigatin	is. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all s present. That staff hed in basic first aid hagement, currently trained honary resuscitation and h maneuver or other first aid hose provided by Red Cross, association or their ving airway obstruction.	V 108			
	received training to m served affecting 8 of (Licensee #1/Director Licensee #2/Executiv Professional, Staff #4 and Staff #9) and 2 o (Former Staff #11/ Fo	record review, and ity failed to ensure staff neet the needs of the clients 10 audited current staff r/Qualified Professional #1, we Director, Associate 4, Staff #5, Staff #6, Staff #8, f 2 audited former staff ormer Client #A2's rmer Staff #12). The				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVE COMPLETED		
		MHL036-331	B. WING		09	09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
		837 LYN	HAVEN DRIVE				
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE	
V 108	Continued From page	e 3	V 108				
	Intellectual Developm Spectrum Disorder, D Speech and Languag -15 years old; -Undated Universal R	mittent Explosive Disorder, nental Disability Mild, Autism Developmental Disorder of ge; Residential Application sexually inappropriate					
	revealed: -Hire date not recorde -No documentation of or sexually aggressiv -No documentation of treatment plans; -Trained himself in th MH/DD/SAS (Mental Disability/Substance 2/8/18, Person Center Health and Safety da Competency dated 2/2 Confidentiality dated Management and Plat Review on 9/8/20 of I with Division of Healt (DHSR) for the facility -Licensee #1/Director	Professional #1's record ed; f training in human sexuality e youth; f training in client specific e following topics: Health/Developmental Abuse Services) dated ered Thinking dated 2/7/18, ted 2/9/18, Cultural /10/18, Rights and 2/11/18, and Crisis anning dated 2/10/18. initial Licensure Application h Service Regulation y revealed: r/Qualified Professional #1 application dated 5/14/18					
	or sexually aggressiv	r's record revealed: f training in human sexuality					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	31 B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	l.	DDRESS, CITY, STATE	, ZIP CODE		
		837 LYN	HAVEN DRIVE			
BRIGHTEI	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From page	e 4	V 108			
	record revealed: -Hire date of 7/1/19; -No documentation of or sexually aggressive	Associate Professional's f training in human sexuality e youth; f training in client specific				
	-Hire date of 7/1/20; -No documentation of or sexually aggressiv	Staff #4's record revealed: f training in human sexuality e youth; f training in client specific				
	or sexually aggressiv	f training in human sexuality				
	#6's records was uns were made available staff records were set #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	Professional #1 and re Director on 9/4/20 at Is to be sent via fax and 34pm for the records to be				
	revealed: -Hire date of 6/5/20; -No documentation of or sexually aggressive	d 9/9/20 of Staff #8's record f training in human sexuality e youth; f training in client specific				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NA, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET
V 108	Continued From page	e 5	V 108			
	revealed: -Hire date of 12/27/19 -No documentation o or sexually aggressiv -No documentation o treatment plans. Review on 9/8/20 of I Client #A2's Grandme -No hire date recorde -No documentation o or sexually aggressiv -No documentation o treatment plans. Review on 9/9/20 of I revealed: -Hire date of 6/4/20; -No documentation o or sexually aggressiv -No documentation o or sexually aggressiv -No documentation o treatment plans. Interview on 9/21/20 revealed: -Could not recall all th -Sexualized behavior meetings but never h deal with sexualized -Did not feel he need because he worked for Social Services.	f training in human sexuality e youth; f training in client specific Former Staff #11/Former other's record revealed: ed; f training in human sexuality e youth; f training in client specific Former Staff #12's record f training in human sexuality e youth; f training in human sexuality e youth; f training in client specific with Associate Professional he training he received; s were discussed during ad any training on how to behaviors; ed any additional trainings or a local Department of				
	unsuccessful. A pho	on 9/11/20 with Staff #4 was ne message was left at a call back. No call was ever 4				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION (X3 . BUILDING:		E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		I 03	1/29/2020
			IHAVEN DRIVE	,		
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 108	Continued From page	e 6	V 108			
	-Was trained in sexua orientation but could discussed during the identify what "groomi sexualized behaviors -Did not respond whe individualized treatme -Staff #5 had her pho the interview and whi the background. Sta answering questions. was with someone el Staff #5 denied being interview. Interview on 9/11/20 revealed: -Not a good time for a was working at her of	m with Staff #5 revealed: alized behaviors during not identify what was training and could not ng" was in relation to s; en asked about training in ent plans; one on speaker phone during ispering could be heard in ff #5 hesitated prior to . Staff #5 was asked if she se during the interview. g with anyone else during the at 12:36pm with Staff #6 an interview because she				
	#6 was unsuccessful the mailbox was full. the phone 2:11pm wh series of text messag DHSR surveyor conti informed she would b Interview on 9/11/20 -No training in sexual -No training in individ this job but had traini treatment plans at an	9/11/20 at 2:10pm with Staff . There was no answer and A text message was sent to nich was read at 2:12pm. A ges between Staff #6 and the inued and Staff #6 was be contacted as needed. with Staff #8 revealed: lized behaviors; lualized treatment plans at ng in individualized				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		MHL036-331	B. WING	09		9/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTE	R DAYZ LLC	837 LYN	HAVEN DRIVE				
BRIGHTE		GASTO	NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE	
V 108	Continued From page	e 7	V 108				
	Staff #12 revealed: -No training in sexual -No training in individ -Never had access to Former Client #1; -Did not know Forme Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -Nobody ever told the treatment plans or to clients; -Will ensure all necess the future.	ualized treatment plans; o documents pertaining to r Client #1's diagnoses. with Licensee Professional #1 and					
V 109	10A NCAC 27G .020 QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be no qualified professional (b) Qualified profess professionals shall de and abilities required (c) At such time as a employment system then qualified profess professionals shall de	SSIONALS o privileging requirements for ls or associate professionals. ionals and associate emonstrate knowledge, skills by the population served. a competency-based is established by rulemaking, sionals and associate emonstrate competence. Il be demonstrated by including: edge;	V 109				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MUI 036 334					
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE		09	9/29/2020	
	R DAYZ LLC	837 LYN	IHAVEN DRIVE	, 0002			
51		GASTO	NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
V 109	Continued From page	e 8	V 109				
	NCAC 27G .0104 (18 met the requirements employment system i MH/DD/SAS. (f) The governing bo develop and implement for the initiation of an plan upon hiring each (g) The associate pro- supervised by a quali- population served for	ills; skills; and ionals as specified in 10A B)(a) are deemed to have s of the competency-based in the State Plan for dy for each facility shall ent policies and procedures individualized supervision in associate professional.					
	professionals (Licens Professional #1 and I Professional/Qualifier audited current assoc Professional) failed to skills, and abilities re- served. The findings	record review, and udited current qualified see #1/Director/Qualified Licensed d Professional #2) and 1 of 1 ciate professional (Associate o display the knowledge, quired by the population are:					
	Former Clients #1, #2 revealed:	3/12/20 and 8/18/20 of 2, #3, and #4's records ents completed by the					

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE,		09	9/29/2020
BRIGHTER	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 9	V 109			
	did not include prese strengths, provisiona pertinent social, famil -No initial assessmer review for Former Cli -Former Client #1's tr did not include treatm running away or the u -Former Client #2's tr did not include treatm sexually inappropriate diapers, or hiding use -Former Client #3's tr did not include treatm away, physical aggre local fast food restau -Former Client #4's tr	eatment plan dated 8/4/20 nent strategies to address use of a summer day camp; eatment plan dated 8/7/20 nent strategies to address e behaviors, the use of ed diapers; eatment plan dated 8/6/20 nent strategies for running ssion or job placement at a rant; reatment plan dated 8/6/20 nent strategies for running				
	#8, and Former Staff -There was no certific Associate Profession -Staff #8's certificate a person qualified to administration trainin -Former Staff #12's c	did not have the signature of complete medication g; ertificate was dark and certificate holder name				
	Requirements (V118) Interviews on 8/10/20 #1/Director/Qualified	27G .0209 Medication) for specifics.) - 9/25/20 with Licensee Professional #1 failed to d former staff upon requests				

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING	B. WING		/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RIGHTE	R DAYZ LLC	837 LYNI	HAVEN DRIVE			
BINIOITTEI		GASTON	IA, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 10	V 109			
	Regulation surveyor.					
	revealed: -Hire date not records -No documentation of or sexually aggressiv -No documentation of treatment plans; -Trained himself in the MH/DD/SAS (Mental Disability/Substance	Professional #1's record ed; f training in human sexuality e youth; f training in client specific e following topics: Health/Developmental Abuse Services) dated red Thinking dated 2/7/18, ted 2/9/18, Cultural /10/18, Rights and 2/11/18, and Crisis				
	and para-professiona emergencies, provisio psycho-educational s adolescents, participa meetings, coordinatio	Professional #1's Job e associate professionals ls, oversight of on of direct ervices to children or ation in treatment planning on of each child or nt plan, provision of basic				
	-Nobody ever told the treatment plans or top clients; -Was not aware treat	Professional #1 revealed: on to train in individualized bics to meet the needs of the ment strategies needed to plemented to address the				

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
Wee OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIGHTER DAY2 LLC B37 LYNHAVEN DRIVE GASTONIA, NC 20052 Majin PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY FULL (CACH CORRECTIVE ACTION SHOULD BE RECOULTRY OR LSC IDENTIFYING INFORMATION) PRETX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) OWNER (CACH CORRECTION (CACH CORRECTION (CACH CORRECTION TAG OWNER (CACH CORRECTION (CACH CORRECTIO				A. BUILDING:			
BRIGHTER DAYLED BRIGHTER DAYLED BRIGHTER DAYLED CONTRACT STATEMENT OF DEPRICIPATION PROVIDENTS PLAN OF CORRECTION (EACH CORRECTION MUST DE PRECEDED BYFULL (EACH DEPRICIPATION OR LSC IDENTIFYING INFORMATION) PROVIDENTS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BER (EACH DEPRICIPATION OR LSC IDENTIFYING INFORMATION) PROVIDENTS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BER (EACH CORRECTIVE ACTION SHOULD BER (EACH CORRECTIVE ACTION OF LSC IDENTIFYING INFORMATION) PROVIDENT STATEMENT OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V109 Continued From page 11 V 109 -Signed Staff #9's medication administration training cortificate be Personnel Registry and Criminal Background checks were coupleted Name annual checks were completed on each employee: -Could not identify the unknown female who Former Client #1 went to visit on 7/4/20; -Denied there was lack of privace provided by the Licensed Professional/Qualified Professional #2 although evidence was contradictory; -Denied there was lack of privace provided by the Licensed Professional/Qualified Professional #2 although evidence was contradictory; -Donied there was lack of privace provided by the Licensed Professional/Qualified Professional #2 although evidence was contradictory; -Donied there was lack of privace provided by the Licensed Professional/B2 record movaled: -Licensed as a Clinical Mental Health Counselor. Interview/Observation on 9/10/20 at approximately 2-450m - 3:10m who Licensed Professional/Qualified Professional #2's record movaled: -Licensed as a Clinical Mental Health Counselor. Interview/Observation on 9/10/20 at approximately 2-450m - 3:10m who Licensed Professional/Qualified Professional #2'			MHL036-331	B. WING		09	/29/2020
GASTONIA, NC 28052 CALLONG PROFENDATION DEFICIENCIES DMULTION UNDEXTRACTOR PREEXT ISAMMARY STATEMENT OF DEFICIENCIES TAG ID PREEXT ISAMMARY STATEMENT OF DEFICIENCIES TAG ID PREEXT ISAM DEFICIENCY MUST ER RECEID NY FULL PREEXT ISAM DEFICIENCY ON USE C DENTIFYING MEDIANATION) V 109 Continued From page 11 V 109 -Signed Staff #8's medication administration training certificate but a Registered Nurse provided the training:	NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
Prefix TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTORY OR LSC IDENTIFYING INFORMATION) PREFix TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Colder V 109 Continued From page 11 V 109 V 109 V 109 Signed Staff #0's medication administration training certificate but a Registered Nurse provided the training; V 109 V 109 Image: Control of the approximation training certificate but a Registered Nurse provided the training; V 109 Image: Control of the approximation training certificate but a Registered Nurse provided the training; V 109 Image: Control of the approximation training certificate but a Registered Nurse provided the training; Image: Control of the approximation training certificate but a Registered Nurse provided from the record and replaced when annual checks were completed on each employee; Image: Control of the approximation thread there was lack of proper staffing ratios although evidence was contradictory; Image: Control of the approximation the Licensed Professional/Qualified Professional #2 although evidence was contradictory; Image: Control of the approximation training in Alternatives to Restrictive Interventions and Seclusion. Physical Restriction and Isolation Time-Out for Staff #6. Image: Control of the approximately Image: Control of the approximately 2-4800 and 9/9/20 of the Licensed Professional/Qualified Professional #2 revealed: -Licensed as a Clinical Mental Health Counselor. Image: Control of the approximately Image: Control of the approximately 2-4800 and 9/9/20 at Professional/Qualified Professional #2 revealed: -Employed at t	BRIGHTER	R DAYZ LLC					
 Signed Staff #8's medication administration training certificate but a Registered Nurse provided the training: Many Health Care Personnel Registry and Criminal Background checks were out of compliance because the original checks were removed from the record and replaced when annual checks were completed on each employee; -Could not identify the unknown female who Former Client #1 went to Visit on 7/4/20; -Denied there was lack of proper staffing ratios although evidence was contradictory; -Denied there was lack of services provided by the Licensed Professional/Qualified Professional #2 although evidence was contradictory; -Denied there was lack of proyer or calls to legal guardians although evidence was contradictory; -No comments regarding the lack of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint and Isolation Time-Out for Staff #6. Finding #2 Review on 9/8/20 and 9/9/20 of the Licensed Professional #2's record revealed: -Licensed as a Clinical Mental Health Counselor. Interview/Observation on 9/10/20 at approximately 2/45pm - 3:10pm with Licensed Professional/Qualified Professional #2 revealed: -Employed at the facility and Sister Facility A since 2017; 	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
training certificate but a Registered Nurse provided the training; -Many Health Care Personnel Registry and Criminal Background checks were out of compliance because the original checks were removed from the record and replaced when annual checks were completed on each employee; -Could not identify the unknown female who Former Client #1 went to visit on 7/4/20; -Denied there was lack of proper staffing ratios although evidence was contradictory; -Denied there was lack of services provided by the Licensed Professional/Qualified Professional #2 although evidence was contradictory; -Denied there was lack of privacy on calls to legal guardians although evidence was contradictory; -No comments regarding the lack of incident reporting; -No comments regarding the lack of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint and Isolation Time-Out for Staff #6. Finding #2 Review on 9/8/20 and 9/9/20 of the Licensed Professional/Qualified Professional #2/ Review on 9/10/20 at approximately 2/45pm - 3:10pm with Licensed Professional/Qualified Professional #2 revealed: -Employed at the facility and Sister Facility A since 2017;	V 109	Continued From pag	e 11	V 109			
weekly; -Used virtual sessions during the start of the		training certificate bu provided the training -Many Health Care F Criminal Background compliance because removed from the rea annual checks were employee; -Could not identify th Former Client #1 were -Denied there was la although evidence w -Denied there was la the Licensed Profess #2 although evidence -Denied there was la guardians although evidence -Denied there was la guardians although evidence -No comments regar reporting; -No comments regar Alternatives to Restri Seclusion, Physical F Time-Out for Staff #6 Finding #2 Review on 9/8/20 an Professional/Qualifie revealed: -Licensed as a Clinic Interview/Observatio approximately 2:45pt Professional/Qualifie -Employed at the fac since 2017; -Provided individual a weekly;	 at a Registered Nurse Personnel Registry and a checks were out of the original checks were cord and replaced when completed on each ae unknown female who nt to visit on 7/4/20; ck of proper staffing ratios as contradictory; ick of services provided by sional/Qualified Professional e was contradictory; ick of privacy on calls to legal evidence was contradictory; ding the lack of training in ictive Interventions and Restraint and Isolation d 9/9/20 of the Licensed d Professional #2's record cal Mental Health Counselor. n on 9/10/20 at m - 3:10pm with Licensed d Professional #2 revealed: iiity and Sister Facility A and group therapy twice 				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-331	B. WING		09	09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STATE	, ZIP CODE			
		837 LYNI	HAVEN DRIVE				
BRIGHTE	R DAYZ LLC	GASTON	IIA, NC 28052				
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
V 109	Continued From page	e 12	V 109				
	the beginning of July						
		, ity was 9/2/20 when she saw					
		ho was the only client at the					
	facility;						
	-Upon confirming with	h the Licensed					
		d Professional #2 that the					
		as 9/2/20 to Former Client					
	#A2, the call was suc	Idenly disconnected at					
	2:50pm;	2					
	-Return calls to the L	icensed					
	Professional/Qualifie	d Professional #2's phone					
	made immediately up	oon disconnection of the call					
		d a message was left					
	requesting a return c						
	-Call was returned by						
		d Professional #2 at 2:57pm					
	-	phone battery went dead;					
	-During the return ca						
		d Professional #2 revealed					
	she made a mistake						
	-	ring the initial call. The last facility was 8/2/20 when					
		as the only client at the					
	facility;	as the only cheft at the					
	-	clinical notes via a secured					
		for all clients at both homes					
	from 7/1/20-present t						
	Based upon record re	eviews of Former Clients #1,					
	#2, #3, and #4 and th	eir respective discharge					
		clients in the facility on					
	9/2/20 although the L						
		d Professional #2 initially					
		ast date of service. The					
		rd reviews also indicated that					
		2, #3, and #4 were all					
		on 8/2/20 although the					
		al/Qualified Professional #2					
	⊔uenuiiea oniy ⊢orme	r Client #A2's presence.					

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		B. WING			
	MHL036-331		7/0.0005	09	/29/2020
AME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, NHAVEN DRIVE	ZIP CODE		
RIGHTER DAYZ LLC		NIA, NC 28052			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 109 Continued From	bage 13	V 109			
Review on 9/11/2 Division of Health from the Licensed Professional #2 d revealed: "Good evening, I' conversation on t work and do not f requested docum I will have this infu- tomorrow night w not have access f Review on 9/14/2 DHSR surveyor ff Professional/Qua 9/11/20 at 8:09pn -Licensed Profess notes on Former were sent via an a encrypted email; -No documentation Professional/Qua provided to Former Interview on 9/25, #1/Director/Qualifi Licensee #2/Exect -The Licensed Pro- Professional #2 w Sessions were co of the pandemic a sessions. Finding #3	 0 of email correspondence to Regulation (DHSR) surveyor d Professional/Qualified ated 9/10/20 at 6:54pm m wanted to follow up per our his afternoon. I still currently at oresee being able to get you the entation this evening. However, ormation to you no later than hen I come in from work as I do to these files." 0 of email correspondence to rom the Licensed lified Professional #2 dated in revealed: sional/Qualified Professional #2 Clients #A1, #A2, #A3 and #A4 attachment to a secure and on of Licensed lified Professional #2 services er Clients #1, #2, #3, and #4. 				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		03	1/29/2020
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
V 109 V 110	day operations of the direct care staff regat to the implementatio adolescent's treatment service planning mention assessment and pro- teen/parents which in and needs of client, s family, review of mention scheduling of assess collateral agencies. new Individualized T Interview on 9/21/20 revealed: -Worked as Associat -Filled in as Qualified -Sexualized behavio meetings but never the deal with sexualized -Did not feel he need because he worked the Social Services; -Not sure how often the receive services from Professional/Qualified -Phone calls were suffered staff to listen to the of This deficiency is creating -This deficiency is creating - This deficiency - This	aled: .Management of the day to e group home, supervision of rding responsibilities related n of each child or ent plan, participation in etings, conduct initial gram orientation session with holudes identifying strength strengths and needs of dications, assessment of sment and contact with Participate in development of reatment Plans" with Associate Professional e Professional; d Professional as needed; rs were discussed during had any training on how to behaviors; led any additional trainings for a local Department of or when the clients would n the Licensed d Professional #2; upervised by having the calls on speaker phone for alls. bes referenced into 10A cope (V293) for a Type A1	V 109			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
			5.1//10		-	
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE		09	/29/2020
	ROVIDER OR SUPPLIER		HAVEN DRIVE	, ZIP CODE		
RIGHTE	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE DATE
V 110	Continued From page	e 15	V 110			
	10A NCAC 27G .020 SUPERVISION OF F (a) There shall be no paraprofessionals. (b) Paraprofessional associate professional professional as speci Subchapter. (c) Paraprofessional knowledge, skills and population served. (d) At such time as a employment system then qualified profess professionals shall de (e) Competence sha exhibiting core skills (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making (5) interpersonal ski (6) communication s (7) clinical skills. (f) The governing bo develop and implement for the initiation of the plan upon hiring each	4 COMPETENCIES AND PARAPROFESSIONALS o privileging requirements for a shall be supervised by an al or by a qualified ified in Rule .0104 of this s shall demonstrate d abilities required by the a competency-based is established by rulemaking, sionals and associate emonstrate competence. If be demonstrated by including: edge; ess; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;				
	#2/Executive Director	r) failed to display the d abilities required by the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH (PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 110	Continued From page	e 16	V 110			
	population served. T	he findings are:				
	Review on 9/8/20 and 9/9/20 of Licensee #2/Executive Director's record revealed: -Hire date of 8/1/18; -Did not ensure necessary training to meet the needs of the clients. Review on 9/14/20 of Licensee #2/Executive Director's Job Description revealed: -"Administrators supervise employees at three residential group homes, assist with employee hiring, orientations and reviews, coordinate communication within the residential programs, ensure compliance with policy and procedures, maintain positive professional ethics and attitudes, assist in the development of new procedures, participate in treatment team meetings, on-call 24/7 based on the program's on-call schedule, actively participate in and lead program meetings with other supervisors/managers, participate in your own career and development meetings with agency directors, provide and coordinate quality training to employees by having the ability to train on all program models/plans and on other suggested training, provide on-the-job training to newly hired employees as well as overall staff development, utilize problem solving skills to manage emergency situations/disaster plan review, sit on the QA/QI (Quality Assurance/Quality Improvement) committee, client rights as well as Intervention Advisory committee, review all fatalities"					

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020
iame of Pi	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 110	Continued From page	e 17	V 110			
	 V 110 Continued From page 17 did not include presenting problems, needs and strengths, provisional or admitting diagnosis, and pertinent social, family, and medical history; No initial assessment was made available for review for Former Client #2's; Former Client #1's treatment plan dated 8/4/20 did not include treatment strategies to address running away or the use of a summer day camp; Former Client #2's treatment plan dated 8/7/20 did not include treatment strategies to address sexually inappropriate behaviors, the use of diapers, or hiding used diapers. Former Client #3's treatment plan dated 8/6/20 did not include treatment strategies for running away, physical aggression or job placement at a local fast food restaurant. Former Client #4's treatment plan dated 8/6/20 did not include treatment strategies for running away or job placement at a local fast food restaurant. 					
	Review on 9/9/20 of Associate Professional, Staff #8, and Former Staff #12's record revealed: -There was no certificate of training provided for Associate Professional; -Staff #8's certificate did not have the signature of a person qualified to complete medication administration training; -Former Staff #12's certificate was dark and illegible and had the certificate holder name written on the side margin.					
	Requirements (V118) Interviews on 9/2/20-	9/4/20 with management				

STATE FORM

	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	R DAYZ LLC	837 LYN	HAVEN DRIVE			
		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU		ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pag	e 18	V 110			
	Client #A1 were from					
	-"Was not made awa	re of their needs or				
	challengesnot to th be briefed;"	ne extent we would want to				
		nited information about the				
		1 and Former Client #A1);				
	Licensee #2/Executi					
	forthcoming about th	e needs of the girls when				
	registering the girls for	or camp.				
	Interviews on 8/10/20) - 9/25/20 with Licensee				
	#2/Executive Directo	r revealed:				
		current and former staff upon				
		e Division of Health Service				
	Regulation.					
	Interview on 9/25/20	with Licensee #2/Executive				
	Director revealed:					
	-	em to train in individualized				
		meet the needs of the				
	clients; Was not aware asso	essments needed to include				
		needs and strengths,				
		ng diagnosis, and pertinent				
	social, family, and me					
	-	ment strategies needed to				
	be developed and im	plemented to address the				
	needs of the clients;					
		r/Qualified Professional #1				
	•	dication administration				
	provided the training	t a Registered Nurse				
		, Personnel Registry and				
	Criminal Background					
		the original checks were				
	-	cord and replaced when				
	annual checks were	-				
	employee;					
		e unknown female who				
	Former Client #1 wer	nt to visit on 7/4/20;				1

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NA, NC 28052			
(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 ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 110	Continued From page	e 19	V 110			
	although evidence wa -Denied there was lat the Licensed Profess #2 although evidence -Denied there was lat guardians although e -No comments regard reporting; -No comments regard Alternatives to Restri Seclusion, Physical F Time-Out for Staff #6 This deficiency is cro	ck of services provided by ional/Qualified Professional e was contradictory; ck of privacy on calls to legal vidence was contradictory; ding the lack of incident ding the lack of training in ctive Interventions and Restraint and Isolation				
V 111	PLAN (a) An assessment s client, according to ge the delivery of service be limited to: (1) the client's prese (2) the client's need (3) a provisional or a established diagnosis of admission, except detoxification or othe shall have an establis admission;	5 ASSESSMENT AND ITATION OR SERVICE hall be completed for a overning body policy, prior to es, and shall include, but not enting problem; s and strengths; admitting diagnosis with an s determined within 30 days that a client admitted to a r 24-hour medical program shed diagnosis upon I, family, and medical history;	V 111			

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.	A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 111	Continued From pag	e 20	V 111				
	vocational, as approp (b) When services a establishment and in treatment/habilitation referred to as the "pl	the abuse, medical, and priate to the client's needs. are provided prior to the pplementation of the or service plan, hereafter an," strategies to address the oblem shall be documented.					
	failed to ensure asse prior to the delivery of assessments include and strengths, provis and pertinent social, affecting 4 of 4 audit	and record review, the facility essments were completed					
	Assessment Policy r -"Each consumer identify his/her needs appropriate, the need consumer. A clinical screening/assessme on each individual w	is assessed to appropriately s/problems and if ds of the family of the nt/evaluation is conducted ho presents himself/herself s referred for assessment, cion to determine					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE,		09	0/29/2020
			IHAVEN DRIVE	, ZIF CODE		
BRIGHTE	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
V 111	Continued From page	e 21	V 111			
	be completed within 3 CCA's must be provid (Licensee/Facility) up considered for treatm potential clients shall admission by the QP. Professional/License Counselor/Executive can be done via phor in person with the ref parent/guardian. It w screening form. Scree the residential applica guardian upon admis admitted to the Bright initial admission asse This assessment will date of screening, clic helpful to clients, input and presenting proble CCA)" Review on 8/11/20, 8 Former Client #1's re -Admitted 7/19/20; -Discharged 8/5/20; -Diagnosed with Post Attention Deficit Hype Mood Dysregulation I -13 years old; -Initial assessment co #1/Director/Qualified 6/10/20 did not include needs or admitting diagnosis family, and medical h	be conducted prior to /LPC/ED (Qualified d Professional Director). The screening ne, faxed over information or erring agency or ill be documented on the beening information is also on ation completed by the sion. When a client is ter Dayz Group Home, an essment will be completed. include the client's name, ent triggers, interventions ut from LPC if applicable, ems (usually referenced in /12/20 and 8/18/20 of cord revealed: t-Traumatic Stress Disorder, eractivity Disorder, Disruptive Disorder; ompleted by the Licensee Professional #1 dated and strengths, provisional s, and pertinent social,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09	/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 111	Continued From page	e 22	V 111				
	 V III Continued From page 22 Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #2's record revealed: -Admitted 4/16/19; -Discharged 8/6/20; -Diagnosed with Intermittent Explosive Disorder, Intellectual Developmental Disability Mild, Autisn Spectrum Disorder, Developmental Disorder of Speech and Language; -15 years old; -No initial assessment was available for review; -Two pages of the residential application were submitted in response to the requests for the initial assessment. 						
	made available for re requested via email of second email request 4:06pm as a reminde sent to Licensee #1/E Professional #1 and E Director. On 8/17/20 #2/Executive Director Licensee #1/Director/ would be returning to gone since 8/11/20) a requested assessment Director was still out of	Licensee #2/Executive at 3:45pm, Licensee r called and revealed /Qualified Professional #1 the country (having been and would upload the nts. Licensee #2/Executive of town assisting with a eral arrangements. No					
	Former Client #3's re -Admitted 4/15/20; -Discharged 8/6/20; -Diagnosed with Opp -17 years old; -Initial assessment co	/12/20 and 8/18/20 of cord revealed: ositional Defiant Disorder; ompleted by the Licensee Professional #1 dated					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
				A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
BRIGHTEI	R DAYZ LLC		NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 111	Continued From page	e 23	V 111				
	 did not include presenting problems, needs and strengths, provisional or admitting diagnosis, and pertinent social, family, and medical history; Several pages of the residential application were attached. Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #4's record revealed: -Admitted 4/15/20; -Discharged 8/6/20; -Diagnosed with Oppositional Defiant Disorder; -17 years old; -Initial assessment completed by the Licensee 						
	6/10/20 did not include prese strengths, provisiona pertinent social, fami	Professional #1 dated nting problems, needs and l or admitting diagnosis, and ly, and medical history; e residential application were					
	facility receives a CC Then, the facility com assessment on each with the strengths an universal residential referring party (exam Social Services) worl	Professional #1 and ve Director revealed: sments is as follows: The A with a referral application. upletes its own initial client and combines that					
	Addendum complete Professional/Qualifie no CCA Addendum c transition.	d by the Licensed d Professional #2. There is completed for a lateral					
	Interview on 9/25/20 #1/Director/Qualified alth Service Regulation						

STATEMEN	of Health Service Regu TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	HL036-331 B. WING		- 09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE			
			NIA, NC 28052			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 111	Continued From page	e 24	V 111			
	assessments needed problem, needs and s admitting diagnosis, a and medical history; -The facility had beer assessments by com application completer client responses to th -"What are triggers fo -"What are triggers fo -"What helps you cal -"What happens whe way?" -"What are things you -"Do you understand -"Do you understand -"Do you have conce -"Present problems;" -The facility will ensu comprehensive initial information required	ve Director was not aware I to include presenting strengths, provisional or and pertinent social, family, in developing initial ubing copies of the residential d by the referring party with the following items: or you?" m down?" n you don't get your own u like to do?" why you are here?" rns?" re to complete a more assessment with all in the future.				
		ss referenced into 10A ope (V293) for a Type A1				
V 112	27G .0205 (C-D) Assessment/Treatme	ent/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible pe	ITATION OR SERVICE e developed based on the partnership with the client or erson or both, within 30 days its who are expected to ond 30 days. clude:				

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If continuation sheet 25 of 109

	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE			
		GASTON	NA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From pag	e 25	V 112			
	 projected date of ach (2) strategies; (3) staff responsible (4) a schedule for reannually in consultative responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or 	e; eview of the plan at least ion with the client or legally or both; tion or assessment of				
	failed to develop and address the needs of audited former clients and #4). The finding Review on 8/11/20, & Former Client #1's re -Admitted 7/19/20; -Discharged 8/5/20; -Diagnosed with Pos Attention Deficit Hyp Mood Dysregulation -13 years old;	and record review, the facility I implement strategies to f the clients affecting 4 of 4 s (Former Clients #1, #2, #3, is are: 8/12/20 and 8/18/20 of ecord revealed: at-Traumatic Stress Disorder, eractivity Disorder, Disruptive Disorder;				
	-Undated Universal F revealed a history of	Residential Application running away; y dated 8/5/20 written by				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
				A. BUILDING:			
		MHL036-331	B. WING		09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From pag	e 26	V 112				
	revealed Former Clie away several times; -Treatment plan date treatment strategies the use of a summer Review on 8/11/20, & Former Client #2's re -Admitted 4/16/19; -Discharged 8/6/20; -Diagnosed with Inte Intellectual Developm Spectrum Disorder, I Speech and Languag -15 years old; -Undated Universal F revealed a history of behaviors; -Treatment plan prog revealed: "Client of in different places in too have staff enter h -Treatment plan date treatment strategies	8/12/20 and 8/18/20 of ecord revealed: rmittent Explosive Disorder, nental Disability Mild, Autism Developmental Disorder of ge; Residential Application sexually inappropriate gress update dated 7/23/20 continues to hide her diapers her room, and attempts not ner room to find them" ed 8/7/20 did not include					
	Former Client #3's re -Admitted 4/15/20; -Discharged 8/6/20;	8/12/20 and 8/18/20 of cord revealed: positional Defiant Disorder;					
	-17 years old; -Treatment plan date information regarding of running away;	d 8/6/20 included historical g Former Client #3's history					
	Licensee #1/Director	/ dated 8/6/20 written by /Qualified Professional #1 ent #3 engaged in weekly					

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If continuation sheet 27 of 109

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09	0/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 112	Continued From pag	e 27	V 112			
	treatment strategies					
	Former Client #4's re -Admitted 4/15/20; -Discharged 8/6/20; -Diagnosed with Opp -17 years old;	8/12/20 and 8/18/20 of cord revealed: positional Defiant Disorder; Residential Application				
	Licensee #1/Director revealed Former Clie placement at a local -Treatment plan date	/ dated 8/6/20 written by /Qualified Professional #1 ent #4 had secured job fast food restaurant; ed 8/6/20 did not include for running away or job				
	Client #1 revealed:) and 9/1/20 with Former vay from the facility at least				
	recreational facility ir Former Client #A1; -While at camp, Form	ner Client #1 and Former verbal altercation and both				
	-	not allowed to return to the				
	members at the local neighboring town wh	9/4/20 with management I recreational facility in a ere Former Client #1 and tended summer day camp				

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING:			
		MHL036-331	036-331 B. WING		09/29/2020	
NAME OF PRO	OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTER	DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From pag	e 28	V 112			
	Client #A1 were from "Was not made awa challengesnot to the be briefed;" -Can not provide servare are not aware of the -After the incident be Former Client #A1, the needs of the camper camp staff could han -Group home staff di- during the day; -Former Client #1 "pt Client #A1 and "the ge -Former Client #1 "pt Client #A1 and "the ge -Former Client #1 "at staff;" -The police were call Client #A1 but she had arrival of the police; -Former Client #1 was camp after the incide Client #A1 but Forme stay; -"We just had very lir girls (Former Client # -Prior to being dismis had previously been camp in a second ne under the same pare -Licensee #2/Executi forthcoming about the registering the girls for -The camp employed a degree in psycholo counseling. The coo coaching campers du	re of their needs or ne extent we would want to vices effectively if the staff needs of the children; tween Former Client #1 and ne camp staff realized the s were greater than what the dle; d not stay with the campers hysically assaulted" Former girls were in a violent fight;" tempted to attack (camp) ed to de-escalate Former d calmed down prior to the as immediately released from ent of assaulting Former er Client #A1 was allowed to nited information about the f1 and Former Client #A1); ased from the camp, they dismissed from another ighboring town which fell nt company; we Director was not e needs of the girls when or camp; I two coordinators: one had gy and one had a degree in rdinators assisted with uring behavioral concerns. g was limited to verbal lisagreement and did not				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		MHL036-331	B. WING		00	09/29/2020	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		08	/29/2020	
				, 2.1. 0002			
BRIGHTE	R DAYZ LLC		NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From page	e 29	V 112				
	campers.						
	mother and Former (revealed:	with Former Client #2's Client #2's foster mother ore diapers due to urinary					
	Former Client #4 rev	cement at a local fast food					
	to be developed and -Former Client # facility or the use of s -Former Client # behaviors, the use of diapers; -Former Client # job placement at a loc -Former Client # placement at a local -Will ensure all treatm	Professional #1 and ve Director revealed: treatment strategies needed implemented to address: 1's running away from the summer day camp; 2's sexually inappropriate f diapers, or hiding used 3's physical aggression or ical fast food restaurant; 4's running away or job fast food restaurant. nent needs with gies are included in the					
	-	oss referenced into 10A ope (V293) for a Type A1					
V 118	27G .0209 (C) Medic	ation Requirements	V 118				
	10A NCAC 27G .020 REQUIREMENTS	9 MEDICATION					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-331	B. WING		09	/29/2020	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE			
RIGHTEI	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From page	e 30	V 118				
	 only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu administered only by unlicensed persons t pharmacist or other la privileged to prepare (4) A Medication Adm all drugs administere current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, at (C) instructions for at (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record 	n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The					
	This Rule is not met Based on interview a failed to ensure staff medication administr registered nurse, pha	nd record review, the facility received training in ation completed by a					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09	/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTEI	R DAYZ LLC		NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From pag	e 31	V 118				
	staff (Associate Prof	cting 2 of 10 audited current essional and Staff #8) and 1 staff (Former Staff #12). The					
	Review on 9/9/20 of Associate Professional's record revealed: -Hire date 7/1/19; -No documentation of training in medication administration.						
	revealed: -Hire date of 6/5/20; -Medication administ dated 5/26/20. The clear. The trainer's s does not match the e other medication adm certificates for the ag	gency. The trainer's o the signature of Licensee					
	administration trainin via email on 9/10/20 request was sent to #1/Director/Qualified Licensee #2/Execution request revealed the	Professional #1 and ve Director. The email need for an "additional copy ation certificate (the one lifficult to read)." No					
	revealed: -Hire date of 6/4/20; -Medication administ 5/28/20 signed by th	Former Staff #12's record tration certificate dated e Registered Nurse who on administration training for					

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE			
		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From page	e 32	V 118			
		tificate was dark and difficult f #12's name was hand f the certificate.				
	revealed:	with Associate Professional he trainings he received but				
	believed he may hav	e been trained in medication uld not recall who provided				
	-Employed as a Direct step in as House Mait -Received training in but cannot recall who -Recalled staff at the	medication administration completed the training; facility helped with				
	medication administrative Interview on 9/22/20 revealed:	with Former Staff #12				
	Facility A;	ts at the facility and Sister as a Direct Care Worker;				
	technician from anoth	se she was a medication ner job;				
	the facility;	gistered Nurse for training at aining when she started the				
	who provided the age medication administr	with the Registered Nurse ency's previous training for ation was unsuccessful. The				
	requested via email of Licensee #1/Director	e Registered Nurse was on 9/10/20 at 2:44pm from /Qualified Professional #1 ecutive Director. There was				
	no response to the re					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 09/29/2020	
		MHL036-331	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	TION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
V 118	Continued From page	33	V 118			
	signed Staff #8's med training certificate but provided the training; -Staff do not recall wh because of the multip -All staff were trained by a Registered Nurs This deficiency consti with a previous citation This deficiency is cross	Professional #1 and e Director revealed: /Qualified Professional #1 lication administration a Registered Nurse no provided training to them le trainings they received; in medication administration e. tutes a recited deficiency,				
V 131	Verification G.S. §131E-256 HEA REGISTRY (d2) Before hiring hea health care facility or health care facility sha Personnel Registry at of access in the appro	as evidenced by:	V 131			
		nd record review, the facility				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 131	Continued From page	e 34	V 131			
	Registry (HCPR) was documented prior to affecting 7 of 10 audi #1/Director/Qualified #2/Executive Directo Staff #8, and Staff #9 staff (Former Staff #1 Grandmother and Fo findings are: Review on 9/8/20 and	Professional #1's record ed;				
	with the Division of H the facility revealed: -Licensee #1/Directo was identified on the	Initial Licensure Application lealth Service Regulation for r/Qualified Professional #1 application for initial 18 and on the license issued				
	Review on 9/8/20 and #2/Executive Directo -Hire date of 8/1/18; -HCPR check comple	r's record revealed:				
	-Hire date of 7/1/20; -HCPR check comple	Staff #4's record revealed: eted 6/23/20; pleted between 6/16/20 and				
	Review on 9/9/20 wit -Hire date of 6/24/20 -HCPR completed 6/ -Agency training com	;				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COM	SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
V 131	Continued From pag	e 35	V 131			
	6/24/20.					
	#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executi 9:53am for the recor- again on 9/8/20 at 1: sent via secured and Review on 9/8/20 an revealed: -Hire date of 6/5/20; -HCPR check compl -Agency training com 6/3/20.	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be d encrypted email. d 9/9/20 of Staff #8's record eted 6/3/20; npleted between 5/20/20 and d 9/9/20 of Staff #9's record				
	-No HCPR check con Review on 9/8/20 of Client #A2's Grandm -No hire date recorde -HCPR check compl	mpleted. Former Staff #11/Former oother's record revealed: ed;				
	revealed: -Hire date of 6/4/20; -HCPR check compl	Former Staff #12's record eted 6/3/20; npleted between 5/21/20 and				
	unsuccessful. A pho	on 9/11/20 with Staff #4 was one message was left at a call back. No call was ever				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-331	B. WING		00	09/29/2020	
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE	1 00		
BRIGHTER	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE	
V 131	Continued From page	e 36	V 131				
	received from Staff #	4.					
	-Could not identify th started, but believed	with Staff #5 revealed: e specific date employment it was in Spring, 2020. with Staff #8 revealed:					
	-Start date was 5/5/2	0.					
	Interview on 9/2/20 w revealed: -Start date was 5/22/						
	which they were finan a bonus; -The hire date in the were officially hired a -Many HCPR checks because the original removed from the red annual HCPR checks employee; -Will complete HCPR staff; -Will keep original HC record in the future.	Professional #1 and ve Director revealed: and received training for ncially compensated through record reflected when they fiter training was completed; were out of compliance HCPR checks were cord and replaced when s were completed on each & checks prior to training new CPR checks in the employee					
	-	ss referenced into 10A ope (V293) for a Type A1					
V 133	G.S. 122C-80 Crimin	al History Record Check	V 133				
	G.S. §122C-80 CRIM CHECK REQUIRED	IINAL HISTORY RECORD FOR CERTAIN					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09	/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTEI	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN C (EACH CORRECTIVE AC		(X5) COMPLETI	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIE) THE APPROPRIATE	DATE	
V 133	Continued From page	e 37	V 133				
	APPLICANTS FOR EMPLOYMENT.						
	(a) Definition As us	ed in this section, the term					
	"provider" applies to	an area authority/county					
	program and any pro	vider of mental health,					
	developmental disab	ility, and substance abuse					
		able under Article 2 of this					
	Chapter. (b) Requirement An offer of employment by a						
	•	der this Chapter to an					
		tion that does not require the					
		occupational license is ent to a State and national					
	criminal history record check of the applicant. If						
	the applicant has been a resident of this State for						
	less than five years, then the offer of employment						
	•	isent to a State and national					
	criminal history recor	d check of the applicant. The					
	national criminal histo	ory record check shall					
	include a check of the	e applicant's fingerprints. If					
		en a resident of this State for					
		en the offer is conditioned					
		e criminal history record					
		it. A provider shall not					
		who refuses to consent to a					
	-	d check required by this herwise provided in this					
	•	e business days of making					
		of employment, a provider					
		st to the Department of					
		14-19.10 to conduct a					
		d check required by this					
		it a request to a private					
	-	ate criminal history record					
		s section. Notwithstanding					
		Department of Justice shall					
		national criminal history					
		ployment positions not					
	covered by Public La						
	Department of Health	1 and Human Services	1			1	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		00	09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		08	5/29/2020	
BRIGHTE	R DAYZ LLC		NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 133	Continued From page	e 38	V 133				
	history of the person, and Human Services Unit, shall notify the p information received of the applicant. In no national criminal histor with the provider. Pro- upon request verifica check has been comp by this section. A cour appropriate local ordi the Division of Crimin may conduct on beha criminal history recor- section without the pr request to the Depart case, the county shal criminal history recor- section within five bus conditional offer of er All criminal history inf provider is confidentia except to the applican (c) of this section. Fo subsection, the term business regularly en criminal history recor- records obtained from (c) Action If an app record check reveals a relevant offense, th of the following factor hire the applicant: (1) The level and seri (2) The date of the cri	eipt of the national criminal the Department of Health , Criminal Records Check provider as to whether the may affect the employability o case shall the results of the ory record check be shared oviders shall make available tion that a criminal history pleted on any staff covered unty that has adopted an nance and has access to nal Information data bank alf of a provider a State d check required by this rovider having to submit a timent of Justice. In such a II commence with the State d check required by this siness days of the mployment by the provider. formation received by the al and may not be disclosed, nt as provided in subsection r purposes of this "private entity" means a tagaged in conducting d checks utilizing public n a State agency. licant's criminal history one or more convictions of the provider shall consider all rs in determining whether to tousness of the crime.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTER	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
()(1)10		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI
V 133	Continued From pag	e 39	V 133			
	(4) The circumstance	es surrounding the				
	commission of the cr					
		en the criminal conduct of				
	the person and the jo	bb duties of the position to be				
	filled.					
	(6) The prison, jail, p					
		nployment records of the				
		e the crime was committed.				
	• •	commission by the person of				
	a relevant offense.	n of a relevant offense alone				
		employment; however, the				
		e considered by the provider.				
		lifies an applicant after				
		relevant factors, then the				
	provider may disclos	e information contained in				
	the criminal history re	ecord check that is relevant				
		n, but may not provide a copy				
	of the criminal history applicant.	f the criminal history record check to the policant.				
	(d) Limited Immunity	A provider and an officer				
	or employee of a pro	vider that, in good faith,				
	complies with this se	ction shall be immune from				
	civil liability for:					
	. ,	provider to employ an				
		is of information provided in				
	-	ecord check of the individual.				
		an employee's history of ne employee's criminal				
		is requested and received in				
	compliance with this					
	-	As used in this section,				
	. ,	eans a county, state, or				
		ry of conviction or pending				
		, whether a misdemeanor or				
		on an individual's fitness to				
		or the safety and well-being of				
		ntal health, developmental				
	disabilities, or substa	ince abuse services. These				1

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE			
	1		NA, NC 28052			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 133	Continued From pag	e 40	V 133			
	Issuing Monetary Su Endangering Executi Article 6, Homicide; A Sex Offenses; Article Kidnapping and Abdu Injury or Damage by Incendiary Device or and Other Housebrea Other Burnings; Article Robbery; Article 18, I False Pretenses and Obtaining Property o Fraudulent Use of Cr Article 19B, Financia Act; Article 20, Fraud 26, Offenses Against Decency; Article 26A Article 27, Prostitutio 29, Bribery; Article 3	ve and Legislative Officers; Article 7A, Rape and Other e 8, Assaults; Article 10, uction; Article 13, Malicious Use of Explosive or Material; Article 14, Burglary akings; Article 15, Arson and de 16, Larceny; Article 17, Embezzlement; Article 19, Cheats; Article 19A, r Services by False or redit Device or Other Means; I Transaction Card Crime Is; Article 21, Forgery; Article				
	Article 39, Protection Protection of the Fan Intoxication; and Artic Crime. These crimes sale of drugs in viola Controlled Substance 90 of the General Sta offenses such as sale violation of G.S. 188- impaired in violation G.S. 20-138.5. (f) Penalty for Furnish applicant for employr supplies, or otherwise	cle 60, Computer-Related also include possession or tion of the North Carolina es Act, Article 5 of Chapter atutes, and alcohol-related e to underage persons in				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		MHL036-331	B. WING		09	9/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page	e 41	V 133			
	shall be guilty of a CI (g) Conditional Employ employ an applicant obtaining the results check regarding the a following requiremen (1) The provider shal prior to obtaining the criminal history recor subsection (b) of this fingerprint cards as re (2) The provider shal criminal history recor business days after th conditional employme 2001-155, s. 1; 2004	of a criminal history record applicant if both of the ts are met: I not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five he individual begins				
	failed to ensure crimi completed within five conditional offer of er audited current staff #1/Director/Qualified #2/Executive Director and 2 of 2 audited for #11/Former Client #A Former Staff #12). T Review on 9/8/20 and	nd record review, the facility nal background checks were business days of making a mployment affecting 5 of 10 (Licensee Professional #1, Licensee r, Staff #6, Staff #8, Staff #9) rmer staff (Former Staff x2's Grandmother and he findings are:				
	#1/Director/Qualified revealed: -Hire date not recorded	Professional #1's record ed:				

STATEMENT	of Health Service Regu r OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page	e 42	V 133			
	-Criminal background 1/30/19.	d check completed on				
	with the Division of H the facility revealed: -Licensee #1/Director was identified on the	Initial Licensure Application lealth Service Regulation for r/Qualified Professional #1 application for initial '18 and on the license issued				
	Review on 9/8/20 and #2/Executive Director -Hire date of 8/1/18; -No criminal backgrou					
	#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be				
	revealed: -Hire date of 6/5/20; -Criminal background	d 9/9/20 of Staff #8's record d check completed 6/3/20; apleted between 5/20/20 and				
	revealed: -Hire date of 12/27/19 -Criminal background	d 9/9/20 of Staff #9's record 9; d check completed 12/20/19; npleted between 12/3/19 and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE		09	/29/2020
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page	e 43	V 133			
	Client #A2's Grandma -No hire date recorde -Criminal background -Agency training com Review on 9/9/20 of I revealed: -Hire date of 6/4/20; -Criminal background -Agency training com 6/15/20. Interview on 8/10/20 Director revealed: -Had a pending child neighboring county; -The charge involved -It was a misundersta cleared and the charg -The case will be hea Interview on 9/11/20 -Start date was 5/5/20 Interview on 9/2/20 w revealed: -Start date was 5/22/2 -After having worked approximately 1 mon fingerprints taken for check.	A check completed 12/21/19; pleted in 2018 and 2019. Former Staff #12's record A completed 6/3/20; pleted between 5/21/20 and with Licensee #2/Executive abuse charge in a her son; anding and she will be ge expunged; and in court on 12/4/20. with Staff #8 revealed: 0. vith Former Staff #12 20; at the facility for th, was asked to get her a criminal background with Licensee Professional #1 and				
	a bonus;	record reflected when they				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED	
		MHL036-331	B. WING		09	09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTE	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
V 133	Continued From page	e 44	V 133				
		fter training was completed; ground checks were out of					
	compliance because	the original HCPR checks he record and replaced					
	when annual crimina	l background checks were					
	completed on each e -Will complete crimin	mployee; al background checks prior					
	to training new staff;						
	-Will keep original cri the employee record	minal background checks in in the future.					
		ss referenced into 10A					
	NCAC 27G .1701 Sc rule violation.	ope (V293) for a Type A1					
V 293	27G .1701 Residenti	al Tx. Child/Adol - Scope	V 293				
	10A NCAC 27G .170						
	 (a) A residential trea children or adolescer 	tment staff secure facility for nts is one that is a					
	free-standing resider	itial facility that provides					
		apeutic treatment and					
		system of care approach. It ary residence of an individual					
	who is not a client of	•					
		ins staff are required to be					
	•	leep hours and supervision					
	shall be continuous a this Section.	is set forth in Rule .1704 of					
		erved shall be children or					
		e a primary diagnosis of					
	mental illness, emotio						
		sorders; and may also have					
	-	rs including developmental					
		nildren or adolescents shall npatient psychiatric services.					
		dolescents served shall					
	require the following:						
	(1) removal fro						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
BRIGHTER	R DAYZ LLC					
			NIA, NC 28052	PROVIDER'S PLAN (
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 293	Continued From page	e 45	V 293			
	community-based res facilitate treatment; a (2) treatment in (e) Services shall be (1) include indi structure of daily livin (2) minimize the related to functional of (3) ensure safe control behaviors inc management with or (4) assist the of acquisition of adaptive communication, social (5) support the gaining the skills nee intensive treatment s (f) The residential trees shall coordinate with agencies within the of of care. This Rule is not met Based on interview, r observation, the facil	sidential setting in order to nd n a staff secure setting. e designed to: vidualized supervision and g; e occurrence of behaviors deficits; ety and deescalate out of luding frequent crisis without physical restraint; hild or adolescent in the re functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting. eatment staff secure facility other individuals and hild or adolescent's system				
	living, minimize the or related to functional of	ision and structure of daily ccurrence of behaviors deficits, ensure safety and ntrol behaviors, assist in the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE	09	09/29/2020	
			HAVEN DRIVE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	e 46	V 293			
	treatment setting affecting 4 of 4 audited former clients (Former Clients #1, #2, #3, and #4). The findings are:					
	Personnel Requirem Based on interview, r observation, the facil received training to n served affecting 8 of (Licensee #1/Directo Licensee #2/Executiv Staff #6, Associate P Staff #9) and 2 of 2 a					
	Competencies of Qua Associate Profession Based on interview, r observation, 2 of 2 as professionals (Licens Professional #1 and Professional/Qualifie audited current assoc Professional) failed to	record review, and udited current qualified see #1/Director/Qualified				
	Competencies and S Paraprofessionals (V Based on interview a audited current parap #2/Executive Directo	-				

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		00)/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		12512020
			IHAVEN DRIVE	,		
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 293	Continued From page	e 47	V 293			
	Service Plan (V111) Based on interview a failed to ensure asse prior to the delivery of assessments include and strengths, provis and pertinent social, affecting 4 of 4 audite Clients #1, #2, #3, ar CROSS REFERENC Assessment and Trea Service Plan (V112) Based on interview a failed to develop and address the needs of	d presenting problem, needs ional or admitting diagnosis, family, and medical history ed former clients (Former				
	Medication Requirem Based on interview a failed to ensure staff medication administr registered nurse, pha qualified person affec staff (Associate Profe	nd record review, the facility received training in				
	Based on interview a failed to ensure the H Registry (HCPR) was documented prior to affecting 7 of 10 audi #1/Director/Qualified #2/Executive Directo	E: General Statute re Personnel Registry (V131) nd record review, the facility lealth Care Personnel s accessed and the results an offer of employment ited current staff (Licensee Director #1, Licensee r, Staff #4, Staff #5, Staff #6, and 2 of 2 audited former				

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	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY IPLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE	, ZIP CODE		5/25/2020
RDIGUTEI	R DAYZ LLC	837 LYN	HAVEN DRIVE			
BRIGHTE		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 293	Continued From pag	e 48	V 293			
		staff (Former Staff #11/Former Client #A2's Grandmother and Former Staff #12).				
	Criminal History Rec Based on interview a failed to ensure crimi completed within five conditional offer of en audited current staff #1/Director/Qualified #2/Executive Director and 2 of 2 audited fo #11/Former Client #4 Former Staff #12). CROSS REFERENC Minimum Staffing Re Based on interview, n observation, the facil care staff when one, were present and fail clients when they we	and record review, the facility inal background checks were business days of making a mployment affecting 5 of 10 (Licensee Professional #1, Licensee r, Staff #6, Staff #8, Staff #9) rmer staff (Former Staff A2's Grandmother and CE: 10A NCAC 27G .1704 equirements (V296)				
	Requirements of Lice Based on interview, i observation, the facil face-to-face clinical of hours per week with					
	Additional Rights in a Based on interview a failed to ensure comm with parents or guard individual having lega	a 24-Hour Facility (V364) and record review, the facility munication and consultation				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		NUL 020 224	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE	. ZIP CODE	09	/29/2020
	R DAYZ LLC		IHAVEN DRIVE	,		
51.101112		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 293	Continued From pag	e 49	V 293			
	clients (Former Clien	t #1).				
	Incident Response R and B Providers (V36 Based on interview a	nd record review, the facility cidents were reported as				
	Incident Reporting R and B Providers (V36 Based on interview a failed to report all Le (local management e	nd record review, the facility vel II incidents to the LME entity) responsible for the re services are provided				
	Training on Alternativ Interventions (V536) Based on interview a failed to ensure staff	nd record review, the facility were trained in alternatives tions affecting 1 of 10				
	Training in Seclusion Isolation Time-Out (N Based on interview a failed to ensure staff	nd record review, the facility were trained in seclusion, d isolation time-out affecting				
	revealed:	with Former Client #1 arty at a staff members'				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			2.1/10				
		MHL036-331	I		/29/2020		
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTEI	R DAYZ LLC		NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From pag	e 50	V 293				
	Continued From page 50 -Identified the female staff member by first name only; -Was left alone with the female staff member, her husband, and her children (identified by Former Client #1 as a 12 to 13-year-old daughter and a younger son). Interview on 9/1/20 with Former Client #1 revealed: -Was adamant she went to a party on 7/4/20 with a female staff member she identified by first name only; -Was left alone with the female staff member's family; -The female staff member worked at the facility						
	and Sister Facility A; -Could not remembe last name. Interview on 9/25/20 #1/Director/Qualified Licensee #2/Director	r the female staff member's with Licensee Professional #1 and					
	Client #1; -Former Client #1 wa	nale identified by Former as at the facility on 7/4/20; y no clients being served at Facility A.					
	female could not be i	ion gathered, the unknown dentified. No other clients or identify the unknown female					
	dated 9/29/20 signed	f the first Plan of Protection l by Licensee Professional #1 revealed:					
	ensure the safety of	ion will the facility take to the consumers in your care? ew Start (facility) does not					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	e 51	V 293			
	facility. That being s the following actions	r direct care staff in this aid, Fresh New Start will take to ensure the safety of when residents and direct e facility.				
	V108: Fresh New Start (the "agency") will comply with all requirements of 10A NCAC 27G .0202 including:a. Enforcing the requirement that that all applicants for employment disclose any criminal					
	conviction. b. A file shall be ma employee indicating	aintained for each individual the training, experience and				
	c. qualifications for	verification of licensure, registration or				
	provided and, at a m following:	provided and, at a minimum, shall consist of the				
	()	t rights and confidentiality as CAC 27C, 27D, 27E, 27F and				
	health/developmenta needs of the client as					
	treatment/habilitation (5) training in infect bloodborne pathoger	tious diseases and ns.				
	returning staff to hav and to retake compe	ncy will require all new and e new background checks tency-based training in Item ersonnel files will be audited				
	to ensure compliance					
		art will comply with all NCAC 27G .0203 including				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE		09	9/29/2020
				, ZIF CODE		
BRIGHTEI	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	e 52	V 293			
	Professional. Specific Professional will rece trainer within the 23 of 1. technical knowle 2. cultural awarene 3. analytical skills; 4. decision-making 5. interpersonal ski 6. communication s 7. clinical skills. V110: Fresh New Sta requirements of 10A ensuring the compete Professionals. Specifi Professionals will rec trainer within the 30 of 8. technical knowle 9. cultural awarene 10. analytical skills; 11. decision-making 12. interpersonal ski 13. communication s 14. clinical skills. V111&V112: Fresh N requirements of 10A a. Enforcing the re- assessment shall be prior to the delivery of not be limited to: 1. the client's prese 2. the client's need 3. a provisional or a established diagnosis of	cally, the Qualified eive training by a qualified days about: edge; ess; ; ; ; ;; ;; ;; ;; ;; ;; ;; ;; ;; ;;				
		pt that a client admitted to a r 24-hour medical program shed diagnosis upon				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
			B. WING			//
	ROVIDER OR SUPPLIER	MHL036-331	DDRESS, CITY, STATE		09	/29/2020
			HAVEN DRIVE	, 211 0002		
BRIGHTE	R DAYZ LLC	GASTON	IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 53	V 293			
	 5. a pertinent social and 6. evaluations or as psychiatric, substance vocational, as 7. appropriate to the b. Enforcing the react Person-Centered Plastarting services that address the client's pwill include all eleme 27G .0205(d)(1-6). V118: Fresh New Starequirements of 10A ensuring all direct cat training by qualified to a. Medication disperient and labeling b. Medication admit c. Medication revier f. Medication educe f. Medication educe g. Medication error In addition, the agent procedure to ensure required elements. A be trained in its requirements of modeling with medication will contract with a moversee its medication effective professional will contract will be kep V131: Fresh New Stare 	al, family, and medical history; ssessments, such as be abuse, medical, and the client's need quirement that a an be developed prior to includes strategies to presenting problem. The plan ints required in 10A NCAC art will comply with all NCAC 271g .0209 including re staff have documented trainer in the following topics: ensing: Medication packaging inistration osal age ew cation rs cy will update its policy and its procedures include all all new and returning staff will irements by a medical egistered nurse, prior to ions. In addition, the agency edical professional to on practices. The medical duct self-audits of medication at monthly. The result of the ot on file.				
vision of Hea		131E-256 including the staff have a Health Care				

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
			B. WING					
	ROVIDER OR SUPPLIER	MHL036-331		B. WING 09/29/2020				
NAIVIE OF PI	ROVIDER OR SUPPLIER		HAVEN DRIVE	, ZIP CODE				
BRIGHTEI	R DAYZ LLC		NIA, NC 28052					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
V 293	Continued From page	e 54	V 293					
	Personnel Registry of Specifically, the ager Personnel Registry of returning staff upon h thereafter. Personnel files will be basis to ensure comp V133: Fresh New Sta requirements of GS of requirement that all s check on file. Specifically, the ager record checks on all upon hire/return and that has not lived in N past 5 consecutive yo Bureau of Investigati The agency will follow 122C-80(c-e) when r decisions. Personnel files will be basis to ensure comp V296: Fresh New Sta requirements of 10A Enforcing the require	heck on file. hcy will conduct Health Care heck on all new and hire/return and annually e self-audited on a quarterly bliance with this standard. art will comply with all 122C-80 including the staff have a criminal record hcy will conduct state criminal new and returning staff prior annually thereafter. Any staff NC (North Carolina) for the ears will have a SBI (State ons) criminal record check. w the requirements of § naking hiring/retention e self-audited on a quarterly bliance with this standard. art will comply with all NCAC 27G .1704 including:						
	telephone or page. A to reach the facility w b. The minimum nu required when childre present and awake is 1. two direct care s	direct care staff will be able within 30 minutes at all times umber of direct care staff en or adolescents are s as follows: staff shall be present for one,						
	to include a requirem	pret 10A NCAC 27G .1704(b) nent that if a (singular) nommunity with staff that two						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		E SURVEY PLETED	
		MHL036-331	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE	, ZIP CODE		5/25/2020
		837 LYN	HAVEN DRIVE			
BRIGHTEI	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 293	Continued From pag	e 55	V 293			
	requirements of 10A a. Enforcing the re- associate level profe (Licensed Clinical So Professional Counse Marriage and Family Associate, Psycholog present on site a min Specifically: 1. The licensed pro- out at the facility. The kept in the record. 2. The licensed pro- i. Documented mo- supervision of the qui in Rule .1702; ii. Individual, group or iii. Involvement in or treatment plans or ow b. As permitted by therapy or activity tim time per beneficiary of in a group for 90 min 90 minutes per beneficiary	boial Worker), LPC (Licensed Therapist), Psychological gist, Psychiatrist will be nimum of 4 hours per week. ofessional shall sign in and e sign in/out sheet will be offessional will provide: onthly formal clinical palified professional specified o or family therapy services; whild or adolescent specific verall program issues. NC DMA CCP 8D2- "Group ne may be included as total (i.e., if there are six members utes, this may be counted as ficiary)."				
	requirements of GS (including GS 122C-6 agency to enforce the minor client who is re					
	Make and receive co In extraordinary circu allows this right to be of § 122C-62(e) are to	our facility has the right to: (1) onfidential telephone calls." umstances § 122C-62(b) e curtailed if the requirements met. § 122C-62(e) states erated in subsections (b) or				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
			A. BUILDING:				
		MHL036-331	B. WING		09	/29/2020	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTER	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	F CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	D THE APPROPRIATE	COMPLET	
V 293	Continued From page	e 56	V 293				
	except by the qualified professional responsible						
		the client's treatment or					
		ritten statement shall be					
		record that indicates the					
		ne restriction. The restriction					
	shall be reasonable a	and related to the client's					
		ion needs. A restriction is					
	effective for a period	not to exceed 30 days. An					
		estriction shall be conducted					
	by the qualified profe	essional at least every seven					
	days, at which time the	he restriction may be					
	removed. Each evalu	ation of a restriction shall be					
	documented in the cl	ient's record. Restrictions on					
	rights may be renewe						
	statement entered by	the qualified professional in					
		at states the reason for the					
		tion." The agency will comply					
	with this requirement						
	To provide an extra la						
		such Person-Centered Plan					
		approved in writing by the					
		hts Behavioral Intervention					
		egally responsible person.					
	0, ,	and Procedure around					
		son-centered planning, and					
	e e	vioral Intervention Committee					
		nall be reviewed/updated to					
	ensure clarity on this	maller.					
	V366: : Fresh New S	tart will comply with all					
		NCAC 27g .0603 including:					
	•	Level II and III incidents are					
	• •	ivision of Health Service					
	Regulation) and the I						
		Managed Care Organization)					
	as required by the pr						
		th and Human Services)					
		ystem (IRIS) within the IRIS					
		.0604 stipulated timeframes.					
	b. The agency will	keep all incident reports on					

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331				09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		09	/29/2020	
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET	
V 293	Continued From pag	e 57	V 293				
		governmental authorities. eturning staff will be retrained					
	in incident reporting	prior to hire/return and					
	annually thereafter. d. The agency will	conduct at least quarterly					
	self-audits to ensure this standard is met						
	-	including cross walking Level I,II, & III progress notes to incident reports.					
	V367 Fresh New Sta						
	requirements of 10A						
	V366.	esponse to response to					
		art will comply with all					
		NCAC 27E .0107 including: choose one Training On					
		ictive Interventions curricula					
		nplete by a qualified trainer					
	will a curriculum appl	27E .0108 . The curriculum roved by the NC					
		eir list of approved curricula.					
	• •	ensure all newly hired and					
		valid Training On Alternatives entions certificate on file					
	before working and a						
	c. The agency will	conduct at least quarterly					
	self-audits to ensure	this standard is met.					
		art will comply with all					
	requirements of NCA						
	Cross reference to re	-sponse to vooo.					
		art will comply with all					
		NCAC 27E .0101 including;					
		staff will provide at promote a safe and					
	respectful environme	-					
	a. using the least re	estrictive and most					
	appropriate settings a alth Service Regulation	and methods;					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED 09/29/2020	
		MHL036-331	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		.DDRESS, CITY, STATE,	ZIP CODE	08	1/29/2020
			HAVEN DRIVE			
BRIGHTEI	R DAYZ LLC	GASTO	NIA, NC 28052			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 293	Continued From page	e 58	V 293			
	 b. promoting coping are alternatives to inj others; c. providing choice: the clients served/sup d. sharing of contro- client/legally responsies e. The use of a resi procedure designed to always be accompanied always be accompanied. f. designed to insurand after the intervention g. using the intervention b. employing the ini- trained in its use. Cropy V536 and V537 V541: Fresh New Star requirements of 10A making reasonable epersonal clothing and theft, damage, destru- misplacement. This w to, assisting the cliene maintaining an invention possessions if the cliene maintaining an invention possessions if the cliene maintaining an invention possession if the cliene maintaining an invention possession behind legally responsible per discovery. Describe your plans to happens. 	g and engagement skills that urious behavior to self or s of activities meaningful to oported; and over decisions with the ible person and staff. trictive intervention to reduce a behavior shall ied by actions re dignity and respect during tion. These include: ntion as a last resort; and tervention only by people tors reference to response to art will comply with all NCAC 27F .0104 including fforts to ensure consumers' a possessions are safe from totion, loss, and will include, but is not limited t in developing and tory of clothing and personal ent or legally responsible acilitate this the agency will all clothes and possessions harge and on a case by ad after a home visit. ner is discharged and leaves the item will mail to the erson within 7 days of				
	As noted in the prear	nble, Fresh New Start does ts or direct care staff in this				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 59	V 293			
	Correction (POC) the actions noted in the a In addition, the agend actions to make sure subsequent POC are a. Contract with a C Care Auditor for threa 1. Conduct quarter sure compliance with subsequent POC. The record. 2. Consult with lead matters. 3. Consult with lead matters. 3. Consult with Clie Intervention Committ 4. Conduct training returning staff about subsequent POC. The live online. The initial available to playback annual retraining. 5. Conduct compet Qualified Professiona live or live online. The recorded and available hires and annual retra b. The agency will facility until such time POP are fully implem Review on 9/29/20 of Protection dated 9/25 #1/Director/Qualified "What immediate act ensure the safety of the content of the safety of the subset of the safet of the content of the safet of the safet of the content of the safet of the safet of the safet of the safet of the content of the safet	a implemented. Certified Forensic Health e months to: Ity self-audits of the agency to this POP and any the self-audits will be in the dership about compliance ent Rights Behavioral see with newly hired and this POP and any the initial training will be live or I training will be recorded and this POP and any the initial training will be live or I training will be recorded and the corder of the second training will be tency-based training will be te initial training will be te to playback for future staff aining. not place residents in the te as all the actions in the tented." If the second Plan of D/20 signed by Licensee Professional #1 revealed: ion will the facility take to the consumers in your care?				
vision of Her	At this time, Brighter does not have any re	the consumers in your care? Dayz (Licensee and Facility) esidents or direct care staff in ng said, Brighter Dayz will				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From pag	e 60	V 293			
	take the following actions to ensure the safety of consumers in its care when residents and direct care staff return to the facility.					
	"agency") will comply NCAC 27G .0202 inc e. Enforcing the re- applicants for employ conviction. f. A file shall be ma employee indicating other	quirement that that all yment disclose any criminal aintained for each individual the training, experience and the position, including				
	certification. h. Employee trainir provided and, at a m following: (1) general organiza (2) training on client delineated in 10A NC (3) 10A NCAC 26B;	ng programs shall be inimum, shall consist of the ational orientation; t rights and confidentiality as CAC 27C, 27D, 27E, 27F and				
	health/developmenta services) needs of the treatment/habilitation (5) training in infect bloodborne pathoger Specifically, the ager	Il disability/substance abuse te client as specified in the plan; and tious diseases and ns. ncy will require all new and e new background checks				
	competency-based to prior to starting work	raining in Item D (1-4) above . All personnel files will be mpliance with this standard. rmation on last page				
	V109: Brighter Dayz requirements of 10A alth Service Regulation	will comply with all NCAC 27G .0203 including				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 61	V 293			
	trainer by 10/18/20: 15. technical knowled 16. cultural awarened 17. analytical skills; 18. decision-making 19. interpersonal skill 20. communication so 21. clinical skills. V110: Brighter Dayz requirements of 10A ensuring the competer Professionals. Specifi returning Para Profess by a qualified trainer 22. technical knowled 23. cultural awarened 24. analytical skills; 25. decision-making 26. interpersonal skills. V111&V112: Brighter requirements of 10A b. Enforcing the re- assessment shall be prior to the delivery of not be limited to: 1. the client's prese 2. the client's need	cally, the Qualified eive training by a qualified edge; ess; ; ;; ills; skills; and will comply with all NCAC 27G .0204 including ency of the Para fically, newly hired and ssionals will receive training prior to starting work. edge; ess; ; ;; ills; skills; and Dayz will comply with all NCAC 27G .0205 including: quirement that an admission completed for all consumers of services, that includes, but enting problem;				
	of 4. admission, exce	s determined within 30 days pt that a client admitted to a r 24-hour medical program				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING			9/29/2020
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	0:	0/29/2020
			HAVEN DRIVE			
SRIGHTER	R DAYZ LLC	GASTON	NA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
V 293	Continued From pag	e 62	V 293			
	and 6. evaluations or as psychiatric, substance vocational, as 7. appropriate to the c. Enforcing the re- Person-Centered Plassing starting services that address the client's pro- will include all element 27G .0205(d)(1-6). V118: Brighter Dayz requirements of 10A ensuring newly hired documented training following topics prior h. Medication dispending i. Medication admit j. Medication admit j. Medication stora l. Medication revier m. Medication educe n. Medication ensurer required elements. A be trained in its requip professional, e.g. a re- dealing with medication will contract with a moversee its medication professional will contract professional will contract pr	e abuse, medical, and le client's need quirement that a in be developed prior to includes strategies to presenting problem. The plan ints required in 10A NCAC will comply with all NCAC 271g .0209 including or returning staff staff have by qualified trainer in the to working: ensing: Medication packaging inistration osal age w sation s cy will update its policy and its procedures include all Il new and returning staff will rements by a medical egistered nurse, prior to ions. In addition, the agency edical professional to on practices. The medical duct self-audits of medication at monthly. The result of the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09	0/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From page	e 63	V 293				
v 255	requirements of GS 1 requirement that all s Personnel Registry c Specifically, the ager Personnel Registry c returning staff upon h thereafter. Personnel files will be basis to ensure comp V133: Brighter Dayz requirements of GS 1 requirement that all s check on file. Specifically, the ager record checks on all upon hire/return and that has not lived in N past 5 consecutive ye record check. The ager requirements of § 12: hiring/retention deciss Personnel files will be basis to ensure comp V296: Brighter Dayz requirements of 10A Enforcing the require c. A qualified profest telephone or page. A to reach the facility w d. The minimum nu required when childred	I 31E-256 including the taff have a Health Care heck on file. acy will conduct Health Care heck on all new and aire/return and annually e self-audited on a quarterly bliance with this standard. will comply with all I 22C-80 including the taff have a criminal record acy will conduct state criminal new and returning staff prior annually thereafter. Any staff NC (North Carolina) for the ears will have a SBI criminal gency will follow the 2C-80(c-e) when making ions. e self-audited on a quarterly bliance with this standard. will comply with all NCAC 27G .1704 including: ments that: ssional shall be available by direct care staff will be able ithin 30 minutes at all times unber of direct care staff en or adolescents are a as follows: taff shall be present for one,					
	to include a requirem	oret 10A NCAC 27G .1704(b) ent that if a (singular) ommunity with staff that two with the consumer.					

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF PROVID	DER OR SUPPLIER	1	ADDRESS, CITY, STATE	, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			HAVEN DRIVE			
BRIGHTER DA	YZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 293 Coi	ntinued From pag	e 64	V 293			
req b. ass (Lic Pro Ma Ass pre Spe 1. out kep 2. i. sup in F ii. or iii. trea c. the time in a 90 V30 req incl age mir hat Ma In e allo of § tha	uirements of 10A Enforcing the re- sociate level profe- censed Clinical So- fessional Counse- rriage and Family sociate, Psycholog- sent on site a mir- ecifically: The licensed pro- at the facility. The ot in the record. The licensed pro- borvision of the que Rule .1702; Individual, group autent plans or ov As permitted by rapy or activity tim e per beneficiary of a group for 90 min- minutes per beneficiary of a group for 90 min- minutes per beneficiary autents of GS (uding GS 122C-6 ency to enforce th- poilitation in a 24-ba- ke and receive co- extraordinary circu- ws this right to be g 122C-62(e) are fit "No right enume	will comply with all NCAC 27G .1705 including: quirement that a licensed or ssional, e.g. LCSW ocial Worker), LPC (Licensed elor), LMFT (Licensed Therapist), Psychological gist, Psychiatrist will be nimum of 4 hours per week. ofessional shall sign in and e sign in/out sheet will be ofessional will provide: onthly formal clinical ralified professional specified of or family therapy services; child or adolescent specific verall program issues. NC DMA CCP 8D2- "Group ne may be included as total (i.e., if there are six members rutes, this may be counted as ficiary)." will comply with all (General Statute) 122C-62 62(d)(1) that requires the e requirement that "each eceiving treatment or our facility has the right to: (1) onfidential telephone calls." umstances § 122C-62(b) e curtailed if the requirements met. § 122C-62(e) states rated in subsections (b) or ay be limited or restricted				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MUL 020 224	B. WING			
		MHL036-331			09	/29/2020
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE IHAVEN DRIVE	, ZIP CODE		
BRIGHTER	R DAYZ LLC		NIA, NC 28052			
(X4) ID			ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN) THE APPROPRIATE	COMPLET DATE
V 293	Continued From page	e 65	V 293			
	except by the qualified professional responsible					
		the client's treatment or				
	habilitation plan. A w	ritten statement shall be				
		record that indicates the				
		ne restriction. The restriction				
	shall be reasonable a	and related to the client's				
	treatment or habilitati	ion needs. A restriction is				
	effective for a period	not to exceed 30 days. An				
	evaluation of each re	striction shall be conducted				
	by the qualified profe	essional at least every seven				
	days, at which time th	he restriction may be				
	removed. Each evalu	ation of a restriction shall be				
	documented in the cl	ient's record. Restrictions on				
	rights may be renewe					
	statement entered by	the qualified professional in				
		at states the reason for the				
	renewal of the restric	tion." The agency will comply				
	with this requirement					
	To provide an extra la					
		such Person-Centered Plan				
		approved in writing by the				
		hts Behavioral Intervention				
		egally responsible person.				
	5 5 5	and Procedure around				
		son-centered planning, and				
	0	vioral Intervention Committee				
		nall be reviewed/updated to				
	ensure clarity on this	matter.				
	V366: : Brighter Dayz					
		NCAC 27g .0603 including:				
		Level II and III incidents are				
		ivision of Health Service				
	Regulation) and the I					
		Managed Care Organization)				
	as required by the pr					
		th and Human Services)				
		ystem (IRIS) within the IRIS				
		.0604 stipulated timeframes.				
	f. The agency will	keep all incident reports on				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 66	V 293			
	file for inspection for g. New hires and re in incident reporting p annually thereafter. h. The agency will self-audits to ensure including cross walki notes to incident report V367 Brighter Dayz w requirements of 10A Cross reference to re V366. V536: Brighter Dayz requirements of 10A d. The agency will Alternatives To Restrict that all staff must cor as defined in NCAC will a curriculum appr DMH/IDD/SAS (Depa Health/Intellectual De Disability/Substance of approved curricula e. The agency will returning staff have w To Restrictive Interve- to working and annual	governmental authorities. eturning staff will be retrained prior to hire/return and conduct at least quarterly this standard is met ng Level I,II, & III progress orts. will comply with all NCAC 27g .0604 esponse to response to comply with all NCAC 27E .0107 including: choose one Training On rictive Interventions curricula mplete by a qualified trainer 27E .0108 . The curriculum roved by the NC artment of Mental evelopmental Abuse Services) on their list a. ensure all newly hired and valid Training On Alternatives entions certificate on file prior ally thereafter. conduct at least quarterly				
	V537: Brighter Dayz requirements of NCA Cross reference to re	C 27E .0108.				
	happens. As noted in the prear	to make sure the above mble, Brighter Dayz does not or direct care staff in this				

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09	9/29/2020	
NAME OF PROVIDER OR	SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
BRIGHTER DAYZ LL	С		HAVEN DRIVE NIA, NC 28052				
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 293 Continue	d From pag	e 67	V 293				
Protection Correction noted in addition, to make are imple c. Con Care Aud 6. Con sure corr subsequi record. 7. Con matters. 8. Con Intervent 9. Con returning subsequi initial trai training v for future 10. Con Qualified training v for future d. The facility un POP are Additiona Regardin Profession 10/18/200 off all din rehire sta concrete	n (POP) and on (POC) the the above in the agency sure the PO emented. tract with a 0 ditor for three duct quarter pliance with ent POC. T sult with lear sult will be record a gency will be record a agency will ntil such time fully implem al Informatio on al will be t . However, aff. Therefor date Associ	with newly hired and this POP and any or to the staff working. The live or live online. The initial ded and available to playback and annual retraining. tency-based training with the al by 10/18/20. The initial live online. The initial ded and available to playback and annual retraining. not place residents in the e as all the actions in the mented.					

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	OF DEFICIENCIES	Ilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING				
	ROVIDER OR SUPPLIER	MHL036-331	B. WING 09/29/2020 ET ADDRESS, CITY, STATE, ZIP CODE 09/29/2020				
	R DAYZ LLC	837 LYN	IHAVEN DRIVE	, 0022			
		GASTO	NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293	Continued From page 68		V 293				
	receive all required to	raining PRIOR to working.					
	Healthcare Auditor. the American Institute (certification is attach Certified Internal For- has a master's in hur and thirty plus years healthcare at local, s agencies including tw	Healthcare Auditor- ertified Internal Forensic [Consultant] is certified by e of Healthcare Compliance hed). [Consultant] is a ensic Healthcare Auditor, mans services administration of experience in behavioral tate and private provider venty years of C-Level (high h quality assurance and					
	surveyor for the Accr Health Care and con accreditation standar regional performance program and the Nor and Community Base	I behavioral healthcare editation Commission for sulted in the development of rds. He has overseen the e of a class action lawsuit th Carolina Medicaid Home ed Waiver. He has been an multi-state provider agency array of services.					
	Illness Management Specialist, and Esser trainer. He is a forme [College] in their Mas person-centered plar	son-Centered Thinking, and Recovery, Peer Support ntial Lifestyle Planning er Field Faculty Adviser with ster's program for nning and systems change. 's website: [website address].					
	Professional will assu	ontract expires the Qualified ume the duties of monitoring POPC and any subsequent					
		s 13 years old and was Traumatic Stress Disorder,					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTE	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC' Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN		ACTION SHOULD BE COM			
V 293	Continued From page	e 69	V 293				
	Disruptive Mood Dys had a history of violer physical aggression, Client #2 was 15 yea with Intermittent Expl Developmental Disat Disorder, and Develo and Language. She physical aggression, sexually inappropriate #3 and Former Client and diagnosed with C Disorder. Former Cl weekly verbal and ph destruction, impulsivi Former Client #4 had and physical aggress The facility did not co assessments inclusiv needs and strengths, diagnosis, and pertiner medical history for Fo There was no admiss for Former Client #2. did not develop and in treatment plans reflect the clients. There we place when clients ra aggressive and assat sexually inappropriate #1 attended a summe Clients #3 and #4 wo restaurant, though the strategies to reflect th Former Client #1 was	ient #3 had a history of ysical aggression, property ty, and running away. a history of weekly verbal ion and running away. mplete admission e of presenting problem, provisional or admitting ent social, family, and ormer Clients #1, #3, and #4. sion assessment completed Furthermore, the facility mplement individualized cting the functional deficits of ere no treatment strategies in n away, displayed ultive behavior, or displayed e behaviors. Former Client er day camp and Former rked at a local fast food ere were no treatment ne use of the camp or jobs. a expelled from the summer of engaging in a physical					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-331	B. WING		09/29/2020		
	ROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP CODE				
BRIGHTE	R DAYZ LLC		NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE	
V 293	Continued From page	ge 70	V 293				
	to meet the needs of training in human se aggressive behavior training for three sta questionable. One received training in J Intervention and Ph and Isolation Time-O Registry and crimina not completed on al The facility did not at telephone calls with was no documentat the Licensed Profess facility did not maint supervision of the of behavioral episodes Former Client #1 ref a female staff membrane name only, after bei This woman was no Incident reporting w Licensee #2/Execut Professional/Qualifie Associate Profession necessary oversight receiving the care ref	staff member had never Alternatives to Restrictive ysical Restraint, Seclusion, Dut. Health Care Personnel al background checks were I staff. Allow clients privacy on their legal guardians. There ion of services provided by sisional. Furthermore, the ain staffing ratios to ensure lients resulting in multiple to occurring at least weekly. ported spending a holiday with ber she would identify by first ng dropped at her home. It identified by either licensee. as not completed. r/Qualified Professional #1, ive Director, Licensed ed Professional #2 and nal failed to provide the t resulting in clients not equired.					
	violation for serious	stitutes a Type A1 rule neglect and must be days. An administrative) is imposed.					
V 296	27G .1704 Residen Staffing	tial Tx. Child/Adol - Min.	V 296				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331			09	9/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 296	Continued From page	e 71	V 296				
	telephone or page. <i>A</i> able to reach the faci times. (b) The minimum nu required when childre present and awake is (1) two direct of one, two, three or fou (2) three direct for five, six, seven or adolescents; and (3) four direct of nine, ten, eleven or the adolescents. (c) The minimum nut during child or adoless follows: (1) two direct of and one shall be away children or adolescer (2) two direct of and both shall be away children or adolescer (3) three direct of which two shall be asleep for nine, ten, e adolescents. (d) In addition to the care staff set forth in Rule, more direct car the facility based on t individual needs as s plan. (e) Each facility shall	asional shall be available by A direct care staff shall be lity within 30 minutes at all mber of direct care staff en or adolescents are as follows: are staff shall be present for ur children or adolescents; care staff shall be present eight children or care staff shall be present for welve children or mber of direct care staff scent sleep hours is as are staff shall be present ake for one through four nts; care staff shall be present ake for five through eight					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE		09	9/29/2020
				, ZIF CODE		
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED DEFIC DEFIC DEFIC			
V 296	Continued From pag	e 72	V 296			
		cility in accordance with the individual strengths and n the treatment plan.				
	care staff when one, were present and fai clients when they we	record review, and lity failed to ensure two direct two, three, or four clients led to ensure supervision of ere away from the facility er clients (Former Clients #1,				
	Former Client #1's re -Admitted 7/19/20; -Discharged 8/5/20; -Diagnosed with Pos	st-Traumatic Stress Disorder, eractivity Disorder, Disruptive				
	-Discharge Summary Licensee #1/Director revealed Former Clie away several times,	y dated 8/5/20 written by /Qualified Professional #1 ent #1 engaged in running aggression with peers, ats and failing to follow				
	Former Client #2's re -Admitted 4/16/19; -Discharged 8/6/20; -Diagnosed with Inte	8/12/20 and 8/18/20 of ecord revealed: rmittent Explosive Disorder, nental Disability Mild, Autism				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			A. BOILDING.			
		MHL036-331	B. WING		09	/29/2020
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From page 73		V 296			
	Speech and Languag -15 years old; -Discharge Summary Licensee #1/Director, revealed Former Clie behaviors, aggressio communicating threa destroying property. Review on 8/11/20, 8 Former Client #3's re -Admitted 4/15/20; -Discharged 8/6/20; -Discharged 8/6/20; -Diagnosed with Opp -17 years old; -Treatment plan date information regarding of running away; -Discharge Summary Licensee #1/Director, revealed Former Clie physical aggression a placement at a local Review on 8/11/20, 8 Former Client #4's re -Admitted 4/15/20; -Discharged 8/6/20; -Discharged 8/6/20; -Diagnosed with Opp -17 years old; -Undated Universal F revealed a history of -Discharge Summary	 dated 8/6/20 written by /Qualified Professional #1 ent #2 engaged in explosive in twice weeks, its, and urinating on self, and ad 12/20 and 8/18/20 of acord revealed: ad 8/6/20 included historical ad 8/6/20 included historical a Former Client #3's history id dated 8/6/20 written by /Qualified Professional #1 ent #3 engaged in weekly and had secured job fast food restaurant. ad 12/20 and 8/18/20 of boositional Defiant Disorder; 				
	revealed Former Clie placement at a local	ent #4 had secured job fast food restaurant. f the facility's Incident				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-331	B. WING		09	9/29/2020
NAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
BRIGHTER	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 296	Continued From page 74		V 296			
	physical altercation b and Former Client ##	ort dated 7/22/20 involved a between Former Client #1 A3 witnessed by Staff #5 here was no documentation of nt.				
	Interviews on 8/13/20 and 9/1/20 with Former Client #1 revealed: -Recalled running away from the facility at least twice; -Attended a summer day camp at a local					
	Former Client #A1; -Former Client #1 go was not allowed to re camp; -One or two staff wor	n a neighboring town with it into a verbal altercation and eturn to the summer day rked per shift - "it depended"				
	- could not identify what it depended upon. Interviews on 9/2/20-9/4/20 with management					
	Former Client #1 and	l recreational facility where d Former Client #A1 attended				
	summer day camp re -Group home staff di during the day.	d not stay with the campers				
	revealed:	with Former Client #3 icement at a local fast food				
	restaurant while livin -Staff would take her -Two staff worked pe	to work and pick her up;				
	revealed:	with Former Client #4				
	restaurant while livin -Staff would take her	to work and pick her up; two staff at the facility but				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		03	12912020
BRIGHTE	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From page	e 75	V 296			
	were two clients present.					
	-Two staff worked pe -Staff #5 had her pho the interview and whi the background. Sta answering questions was with someone el	m with Staff #5 revealed:				
	Interview on 9/21/20 revealed: -Two staff worked pe	with Associate Professional r shift.				
	Interview on 9/11/20 - "Two staff to four cli	with Staff #8 revealed: ents."				
	Staff #12 revealed: -Only one staff prese -Was often left with c and Sister Facility A;	and 9/21/20 with Former nt for three to four clients; lients from both the facility 6/20 with clients from the cility A.				
	Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -Always scheduled tw	Professional #1 and /e Director revealed:				
	This deficiency const with a previous citation	itutes a recited deficiency, on on 9/13/19.				
		ss referenced into 10A ope (V293) for a Type A1				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331 B. WING _				09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	L	DDRESS, CITY, STATE,			12312020	
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NA, 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 297	Continued From page	e 76	V 297				
V 297	297 27G .1705 Residential Tx. Child/Adol - Req. for P		V 297				
	provided in each facil week by a licensed pro- individual who holds a license issued by the a human service profi- Carolina. For substan- shall include a license Specialist or a certifier (b) The consultation this Rule shall include (1) clinical supe professional specifier Section; (2) individual, g services; or (3) involvement	SIONALS cal consultation shall be ity at least four hours a rofessional. For purposes of ofessional means an a license or provisional governing board regulating ession in the State of North nce-related disorders this ed Clinical Addiction ed Clinical Supervisor. specified in Paragraph (a) of e: ervision of the qualified					
		ecord review, and					
	Review on 8/11/20, 8 Former Client #1's re -Admitted 7/19/20;						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PL (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE	
V 297	Continued From page 77 -Discharged 8/5/20;		V 297			
		t-Traumatic Stress Disorder,				
	Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder; -13 years old; -Discharge Summary dated 8/5/20 written by					
	Licensee #1/Director/Qualified Professional #1					
	revealed Former Clie	ent #1 engaged in running				
		aggression with peers,				
	communicating threa directions.	ts and failing to follow				
	Review on 8/11/20, 8	3/12/20 and 8/18/20 of				
	Former Client #2's record revealed:					
	-Admitted 4/16/19;					
	-Discharged 8/6/20;	rmittent Explosive Disorder,				
		nental Disability Mild, Autism				
	•	Developmental Disorder of				
	Speech and Language					
	-15 years old;					
		/ dated 8/6/20 written by				
		/Qualified Professional #1 ent #2 engaged in explosive				
	behaviors, aggressio	88 1				
		ts, and urinating on self, and				
	destroying property.					
		/12/20 and 8/18/20 of				
	Former Client #3's re	cord revealed:				
	-Admitted 4/15/20;					
	-Discharged 8/6/20;	ositional Defiant Disorder;				
	-17 years old;					
	-Treatment plan date	d 8/6/20 included historical				
		g Former Client #3's history				
	of running away;	deted 9/6/00 witters by				
		/ dated 8/6/20 written by /Qualified Professional #1				
	revealed Former Clie					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTER	R DAYZ LLC		HAVEN DRIVE NA, NC 28052			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 297	Continued From page	e 78	V 297			
	physical aggression.					
	Review on 8/11/20, 8/12/20 and 8/18/20 of					
	Former Client #4's re	cord revealed:				
	-Admitted 4/15/20; -Discharged 8/6/20;					
	-Diagnosed with Opp	ositional Defiant Disorder;				
	-17 years old;	Decidential Application				
	revealed a history of	Residential Application running away.				
	Interview on 8/13/20 with Former Client #1 revealed:					
	-Did not remember the name of the Licensed					
	Professional/Qualified Professional #2 but recalled it was a girl therapist and she saw her					
	every other week.	nerapist and she saw her				
	Interview on 9/11/20 revealed:	with Former Client #3				
	-The Licensed Profes					
		d come to the facility once				
	every 2 weeks or onc -The Licensed Profes					
		ot provide therapy weekly.				
	Interview on 9/11/20 revealed:	with Former Client #4				
	-The Licensed Profes	ssional/Qualified				
	Professional #2 would	d come to the facility once				
	every 2 weeks; -The Licensed Profes	acional/Qualified				
		d conduct individual and				
		tual sessions during the early				
	stages of the nationa	•				
	returned to coming to	o the facility.				
	Interview/Observation					
		n - 3:10pm with Licensed d Professional #2 revealed:				
sion of Hea	Ith Service Regulation					

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I <mark>VISION OF HEALTH SERVICE REG</mark> TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		A. BUILDING:			
	MHL036-331	B. WING		09	/29/2020
AME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
RIGHTER DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
V 297 Continued From pag	ge 79	V 297			
-Employed at the fac since 2017; -Provided individual weekly; -Used virtual session pandemic and resur the beginning of July -Last time at the fac Former Client #A2 w facility; -Upon confirming wi Professional/Qualifie last date of service w #A2, the call was su 2:50pm; -Return calls to the I Professional/Qualifie made immediately u went to voicemail ar requesting a return of -Call was returned b Professional/Qualifie who reported her ce -During the return ca Professional/Qualifie she made a mistake calendar correctly d date of service at the Former Client #A2 w facility; -Will send copies of and encrypted emai from 7/1/20-present Based upon record #2, #3, and #4 and t	cility and Sister Facility A and group therapy twice and group therapy twice and group therapy twice and during the start of the med face to face sessions in <i>y</i> ; ility was 9/2/20 when she saw who was the only client at the th the Licensed ed Professional #2 that the was 9/2/20 to Former Client ddenly disconnected at Licensed ed Professional #2's phone pon disconnection of the call and a message was left call; by the Licensed ed Professional #2 at 2:57pm Il phone battery went dead; all, the Licensed ed Professional #2 revealed and did not view her uring the initial call. The last e facility was 8/2/20 when vas the only client at the clinical notes via a secured I for all clients at both homes by 9pm on 9/10/20. reviews of Former Clients #1, heir respective discharge o clients in the facility on				

Division of Health Service Regulation STATE FORM

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		837 LYN	HAVEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTON	NIA, NC 28052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 297	Continued From page	e 80	V 297			
	aforementioned record Former Clients #1, #2 present in the facility Licensed Professional identified only Forme Review on 9/11/20 of Division of Health Re from the Licensed Pro- Professional #2 dated revealed: "Good evening, I'm w conversation on this a work and do not fores requested documenta I will have this inform tomorrow night when not have access to the Review on 9/14/20 of DHSR surveyor from Professional/Qualified 9/11/20 at 8:09pm rev -Licensed Profession #2's notes on Former #A4 were sent via an encrypted email; -No documentation o Professional/Qualified provided to Former C Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -The Licensed Profess Professional #2 was	rd reviews also indicated that 2, #3, and #4 were all on 8/2/20 although the al/Qualified Professional #2 r Client #A2's presence. Femail correspondence to gulation (DHSR) surveyor ofessional/Qualified d 9/10/20 at 6:54pm vanted to follow up per our afternoon. I still currently at see being able to get you the ation this evening. However, ation to you no later than I come in from work as I do nese files." Femail correspondence to the Licensed d Professional #2 dated vealed: al/Qualified Professional Clients #A1, #A2, #A3 and attachment to a secure and f Licensed d Professional #2 services Clients #1, #2, #3, and #4. with Licensee Professional #1 and ve Director revealed: ssional/Qualified at the facility weekly.				
vision of He	9/11/20 at 8:09pm rev -Licensed Profession #2's notes on Former #A4 were sent via an encrypted email; -No documentation o Professional/Qualified provided to Former C Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -The Licensed Profess Professional #2 was Sessions were condu	vealed: al/Qualified Professional c Clients #A1, #A2, #A3 and attachment to a secure and f Licensed d Professional #2 services clients #1, #2, #3, and #4. with Licensee Professional #1 and ve Director revealed: ssional/Qualified				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC					
			NIA, NC 28052			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 297	Continued From page	e 81	V 297			
		ss referenced into 10A ope (V293) for a Type A1				
V 364	G.S. 122C- 62 Additi Facilities	ional Rights in 24 Hour	V 364			
	122C-51 through G.S. who is receiving treat 24-hour facility keeps (1) Send and receive access to writing mat assistance when nec (2) Contact and con- and at no cost to the physicians, and priva developmental disabi- professionals of his c (3) Contact and con- there is a client advoor there is a client advoor The rights specified in restricted by the facili- exercise these rights (b) Except as provid of this section, each a treatment or habilitati- times keeps the right (1) Make and receiv calls. All long distance	a rights enumerated in G.S. 5. 122C-61, each adult client ament or habilitation in a 5 the right to: e sealed mail and have erial, postage, and staff essary; sult with, at his own expense facility, legal counsel, private te mental health, lities, or substance abuse hoice; and sult with a client advocate if cate. In this subsection may not be ty and each adult client may at all reasonable times. led in subsections (e) and (h) adult client who is receiving on in a 24-hour facility at all to: e confidential telephone e calls shall be paid for by of making the call or made				
	(2) Receive visitors a.m. and 9:00 p.m. fo hours daily, two hours	between the hours of 8:00 or a period of at least six s of which shall be after 6:00 g shall not take precedence				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY IPLETED
		MHL036-331	B. WING			9/29/2020
NAME OF P	ROVIDER OR SUPPLIER	I	DDRESS, CITY, STATE,		03	5/25/2020
			HAVEN DRIVE			
BRIGHTE	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From page	e 82	V 364			
	supervision with indiv upon the consent of t (4) Make visits outsi unless: a. Commitment pro- the result of the clien violent crime, includir assault with a deadly respondent was foun insanity or incapable b. The client was ver- committed to the faci commitment to a corr Division of Adult Corr Public Safety; or c. The client is beir to proceed pursuant A court order may ex otherwise prohibited conditions prescribed (5) Be out of doors of facilities and equipme several times a week (6) Except as prohibited personal clothing and client is being held to proceed pursuant to (7) Participate in reli (8) Keep and spend own money; (9) Retain a driver's prohibited by Chapte and (10) Have access to in his private use. (c) In addition to the 122C-51 through G.S.	de the custody of the facility acceedings were initiated as it's being charged with a big a crime involving an weapon, and the d not guilty by reason of of proceeding; oluntarily admitted or lity while under order of rectional facility of the ection of the Department of ag held to determine capacity to G.S. 15A-1002; pressly authorize visits by the existence of the l by this subdivision; daily and have access to ent for physical exercise ; ited by law, keep and use l possessions, unless the determine capacity to G.S. 15A-1002; gious worship; a reasonable sum of his license, unless otherwise r 20 of the General Statutes; ndividual storage space for				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			B. WING			
		MHL036-331			09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
BRIGHTE	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From page	e 83	V 364			
	 24-hour facility has the proper adult supervises recognition of the minimal proper adult supervises recognition of the minimal opportunities to enable emotionally, intellective vocationally. In view and intellectual immal 24-hour facility shall also reasonable efforts to the rights given to the The facility shall also reasonable efforts to client receives treatment adult clients unless the minor client dictate on Each minor client dictate on Each minor client with habilitation from a 24 (1) Communicate and guardian or the agen custody of him; (2) Contact and comor or that of his legally respination of the facility, legiphysicians, private medisabilities, or substathis or his legally respination of the right specified in restricted by the facility may exercise these respination of this section, each the right to: 	nor's status as a developing shall be provided le him to mature physically, ually, socially, and of the physical, emotional, aturity of the minor, the provide appropriate n and control consistent with e minor pursuant to this Part. , where practical, make ensure that each minor nent apart and separate from ne treatment needs of the therwise. o is receiving treatment or -hour facility has the right to: nd consult with his parents or cy or individual having legal sult with, at his own expense esponsible person and at no gal counsel, private tental health, developmental nce abuse professionals, of oonsible person's choice; and sult with a client advocate, if				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	MHL036-331	ADDRESS, CITY, STATE,		09	/29/2020
	CONDER ON SUFFLIER			, ZIF CODE		
BRIGHTER	R DAYZ LLC		NIA, NC 28052			
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETI DATE
V 364	Continued From pag	e 84	V 364			
	time of making the ca	all or made collect to the				
	receiving party;					
	(2) Send and receiv	e mail and have access to				
	writing materials, pos	stage, and staff assistance				
	when necessary;					
		te supervision, receive				
		hours of 8:00 a.m. and 9:00				
		t least six hours daily, two				
		be after 6:00 p.m.; however precedence over school or				
	therapies;	precedence over school of				
		education and vocational				
	. ,	e with federal and State law;				
		daily and participate in play,				
	. ,	ical exercise on a regular				
	basis in accordance	with his needs;				
		pited by law, keep and use				
	personal clothing and					
		ion, unless the client is being				
		pacity to proceed pursuant to				
	G.S. 15A-1002; (7) Participate in rel	igious worship:				
	.,	individual storage space for				
	the safekeeping of pe	U .				
	1 5 1	and spend a reasonable sum				
	of his own money; ar	•				
		license, unless otherwise				
		r 20 of the General Statutes.				
		ated in subsections (b) or (d)				
	-	e limited or restricted except				
	•	essional responsible for the				
		ent's treatment or habilitation				
	-	nent shall be placed in the dicates the detailed reason				
	for the restriction. Th					
		ed to the client's treatment or				
		restriction is effective for a				
		30 days. An evaluation of				
	each restriction shall	-				

AND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 364	Continued From page	e 85	V 364			
	at which time the res Each evaluation of a documented in the cl rights may be renewed statement entered by the client's record that renewal of the restrict client who has not be in each instance of a of a restriction of right by the client shall, up be notified of the restri- it. In the case of a mit adult client, the legal be notified of each in or renewal of a restri- reason for it. Notificat individual or legally re-	ient's record. Restrictions on				
	failed to ensure community with parents or guard individual having lega by the facility affection	nd record review, the facility munication and consultation				
	#1's record revealed: -Admitted 7/19/20; -Discharged 8/5/20;	t-Traumatic Stress Disorder,				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		BUILDING: COI		E SURVEY PLETED
		MHL036-331	B. WING			09/29/2020
IAME OF PI	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE,	ZIP CODE	08	0/29/2020
	R DAYZ LLC	837 LYN	HAVEN DRIVE			
		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 364	Continued From pag	e 86	V 364			
	Mood Dysregulation -13 years old.	Disorder;				
	Interview on 8/13/20 revealed:	with Former Client #1				
	but there were no pri "they (staff) had to m	e phone calls at the facility vate calls allowed because onitor what I was talking				
	about;" -Staff would hang up what was said.	the phone if they did not like				
	-Clients were allowed to 15 minutes with st speaker phone; -Clients were only all	with Staff #5 revealed: d to make phone calls for 10 aff monitoring all calls via lowed to call individuals on t approved by their legal				
	revealed: -Clients were allowed legal guardian appro -Phone calls were mo	with Associate Professional d to make phone calls if their ved of the individuals called; onitored on a client by client calls on speaker phone for				
	-Clients were allowed individuals on their lis the legal guardian; -Calls were monitore -Had clients place the and staff sat next to t	with Staff #8 revealed: d to make phone calls to st of contacts approved by d; e phone on speaker phone the clients and listened to the				
	revealed:	with Former Staff #12				

STATEMEN	of Health Service Regu TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC					
			IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From page	e 87	V 364			
	but all calls needed to telephone on speake	b be monitored with the r phone.				
	calls on speaker phor -Former Client #1's S Former Client #1's ca monitored; -There was no docum Social Worker reques with her mother be m -Was not "running a b privacy on phone call -Clients were allowed wanted, but calls wer call list.	Professional #1 and re Director revealed: ad their phone calls directed to put all personal ne; occial Worker requested Ils with her mother be nentation Former Client#1's sted Former Client #1's calls onitored; pootcamp" with not allowing s; I to use the phone when they e based upon their approved				
		ss referenced into 10A ope (V293) for a Type A1				
V 366	10A NCAC 27G .0603 RESPONSE REQUIF CATEGORY A AND E (a) Category A and E implement written pol response to level I, II shall require the prov (1) attending to of individuals involved (2) determining	REMENTS FOR B PROVIDERS b providers shall develop and licies governing their or III incidents. The policies lider to respond by: b the health and safety needs	V 366			

Division of Health Service Regulation STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		MHL036-331			09	0/29/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From page	e 88	V 366			
	to prevent similar inc specified timeframes (5) assigning p for implementation of preventive measures (6) adhering to set forth in G.S. 75, 4 42 CFR Parts 2 and 164; and (7) maintaining Subparagraphs (a)(1 (b) In addition to the Paragraph (a) of this shall address inciden regulations in 42 CFF (c) In addition to the Paragraph (a) of this providers, excluding develop and implement their response to a let while the provider is a or while the client is of The policies shall rec by: (1) immediated by: (A) obtaining th (B) making a p (C) certifying th (D) transferring review team; (2) convening a review team within 24 internal review team who were not involve	ceed 45 days; and implementing measures idents according to provider not to exceed 45 days; berson(s) to be responsible f the corrections and s; confidentiality requirements Article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and g documentation regarding) through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers ats as required by the federal R Part 483 Subpart I. requirements set forth in Rule, Category A and B ICF/MR providers, shall ent written policies governing evel III incident that occurs delivering a billable service on the provider's premises. quire the provider to respond y securing the client record the client record;				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE,	ZIP CODE	1 .	
RDIGHTE	R DAYZ LLC	837 LYN	HAVEN DRIVE			
DIVIGHTE	N DATZ ELC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From page	e 89	V 366			
	services at the time of review team shall corr follows: (A) review the of determine the facts a and make recomment occurrence of future if (B) gather othe (C) issue writte within five working da preliminary findings of LME in whose catcher located and to the LW if different; and (D) issue a final owner within three may final report shall be se catchment area the p LME where the client final written report shall identified by the inter- include all public doca incident, and shall may minimizing the occurr all documents needed available within three LME may give the pro- three months to subm (3) immediately (A) the LME res- area where the service Rule .0604; (B) the LME with different; (C) the provide for maintaining and u	er information needed; en preliminary findings of fact ays of the incident. The of fact shall be sent to the ment area the provider is ME where the client resides, I written report signed by the onths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The all address the issues nal review team, shall uments pertinent to the ake recommendations for rence of future incidents. If d for the report are not months of the incident, the ovider an extension of up to nit the final report; and y notifying the following: sponsible for the catchment ces are provided pursuant to mere the client resides, if er agency with responsibility				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	R DAYZ LLC	837 LYN	HAVEN DRIVE			
BRIGHTER		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From page	e 90	V 366			
	applicable; and	nent; legal guardian, as nuthorities required by law.				
	failed to ensure all inc	as evidenced by: nd record review, the facility cidents were reported as y and procedure. The				
	Former Client #1's re -Admitted 7/19/20; -Discharged 8/5/20; -Diagnosed with Post	t-Traumatic Stress Disorder, eractivity Disorder, Disruptive				
	revealed a history of -Discharge Summary Licensee #1/Directory revealed Former Clie	v dated 8/5/20 written by /Qualified Professional #1 ent #1 engaged in running aggression with peers, and				
	7/31/20 between Lice and Former Client #1 Services Social Work	email correspondence dated ensee #2/Executive Director 's Department of Social ker revealed: ive Director revealed there				
ision of U-		to terminate services for 'She needs a higher level of				

VALUE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIGHTER DAV2 LLC B37 LYNHAVEN DRIVE GASTONIA, NC 28052 04010 PREFIX TXG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL TXG D PREFIX (EACH DEPICENCY MUST BE PRECEDED BY FULL PREFIX TXG D PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECEDED BY FULL TXG D PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECEDED BY FULL TXG D PREFIX (EACH DEPICENCY AUST BE PRECEDED BY FULL TXG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST BE PRECEDED BY FULL TXG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST BE PRECEDED BY FULL TXG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST BE PRECEDED BY FULL TYG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST BE PRECEDED BY FULL TYG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST BE PRECEDED BY FULL TYG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST BE PRECEDED BY FULL TYG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY TYG PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY AUST AUST AUST AUST AUST AUST AUST AUST		F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
WILL OF PROVIDER OR SUPPLIER STREET ADDRESS, CUTV, STATE, 2/P CODE BRIGHTER DAYZ LLC B37 LYNHAVEN DRIVE GASTOMA, NC 28052 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC DET DE PRECEDED BY FULL RECULATORY OR LSC DE RECEDED BY FULL RECULATORY DE RECULATORY DE RECEDED BY FULL RECULATORY DE RECULATORY DE RECE				A. DOILDING.			
BY LYNHEND RUTE CASTONIA, NY 2002 MANDER DATA LILIC SUMMARY STATEMENT OF DEPICIENCY (EACH DEPICIENCY MUST BE PRECEDED BY FILL) (EACH DEPICIENCY OR USE DEMITYING INFORMATION) PREFIX PAGE PROVIDER'S FLAN OF CORRECTION (EACH CORRECTION CROSS-REFERENCED to THE PADD RPIL CROSS-REFERENCED to THE PADD RPIL DEFICIENCY O V366 Continued From page 91 V 366 V 366 I I V366 Continued From page 91/LD with Former Client #1 revealed: - Recalled running away from the facility at least twice. V 366 I I I Interview on 8/11/20, 8/12/20 and 8/18/20 of Former Client #12's record revealed: - Admitted 4/16/19; Discharged 0/8/20; Disgnosed with Intermitten Explosive Disorder, Intellectual Developmental Disorder of Speech and Language; - 15 years old; Treetiment Disorder, Developmental Disorder of Speech and Language; - 15 years old; Treetiment Disorder to bide her diapers in different places in her room, and attempts not too have staff enter her room to find fmm Client has attempted to destroy group home property several times within the past month. Client has thrown a chair and has punched the wall on multiple occasions. Client has an outburst when she to alable/02 over home property several times within the past month. Client has thrown a chair and has punched the wall on multiple occasions. Client has an outburst when she to alable/04 by writing hy Licenser #10/Director/Qualified Professional #1 revealed explosive behaviors with foul language, aggression			MHL036-331	B. WING		09	/29/2020
NRMEMEE DAY2 LLC GASTONIA, NC 28052 (X4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REAGEDED BY FULL (EACH DEFICIENCY ON USE OF EXCEEDED BY FULL TAG ID PREFIX TAG ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) C V 366 Continued From page 91 V 366 V 366 V 366 care. On yesterday she threatened me as well as the QP (Qualified Professional). She also stated she wants to kill me mother. She told the QP that she was going to chock him with a knife. She told me that she is going to kill me. She attacked a client as well earlier this week." V 366 Interviews on 8/13/20 and 9/1/20 with Former Client #1/ revealed: Recalled running away from the facility at least twice. Review on 8/13/20 and 9/1/20 with Former Client #2's record revealed: Admitted 4/16/19; -Discharged 8/6/20; -Diagnosed with Intermittent Explosive Disorder, Intellectual Developmental Disability Mild, Autism Spectrum Disorder, Developmental Disorder of Speech and Language; -15 years old; -Treatment plan progress update dated 7/23/20 revealed: "Client continues to hide her diapers in different places in her room, and attempts not too have staff enter her room to find them Client has attempted to destroy group home property several times within the past month. Client has his not allowed to go to the store" -Discharge SUMTARY dated 8/6/20 written by Licensee #1/Director/Qualified Professional #1 revealed explosive behaviors with foul language, aggression twice weekly, communicating threats, urinating on seff, and destroying property: -Treatment Plan update dated 8/6/21 projective.	AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
Deficition TAG LEACH DEFICIENCY MIST BE PRECEDED BY FULL RECOLLATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCED TO INFORMATION) PREFIX TAG V 366 Continued From page 91 V 366 V 366 Care. On yesterday she threatened me as well as the QP (Qualified Professional). She also stated she wants to kill her mother. She told the QP that she was going to chock him with a knife. She told me that she is going to kill me. She attacked a client as well earlier this week." Interviews on 8/13/20 and 9/1/20 with Former Client #1 revealed: Recalled running away from the facility at least twice. Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client 4/16/19; -Discharged 8/6/20; -Diagnosed with Intermittent Explosive Disorder, Intellectual Developmental Disorder of Speech and Language; 15 years old; Treatment plan progress update dated 7/23/20 revealed: "Client nontinues to hide her diapers in different places in her room, and attempts not too have staff enter her room to find them Client has attempted to destroy group home property several limes within the past month. Client has intown a chair and has punched the wail on multiple occasions. Client has an outburst when she is not allowed to go to the store," -Discharge Summary dated 8/6/20 written by Licensee #1/Director/Qualified Professional #1 revealed explosive behaviors with foul language, aggression twice weekly, communicating threats, urinating on self, and destroying property; Treattment Plan update dated 3/2/20 revealed Descharge Summary date 3/6/20	BRIGHTE	R DAYZ LLC					
 care. On yesterday she threatened me as well as the QP (Qualified Professional). She also stated she wants to kill her mother. She told the QP that she was going to chock him with a knife. She told me that she is going to kill me. She attacked a client as well earlier this week." Interviews on 8/13/20 and 9/1/20 with Former Client #1 revealed: -Recalled running away from the facility at least twice. Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #2's record revealed: -Admitted 4/16/19; -Discharged 8/6/20; -Discharged 8/6/20; -Discharged 8/6/20; -Disgnosed with Intermittent Explosive Disorder, Intellectual Developmental Disorder of Speech and Language; -15 years old; -Treatment plan progress update dated 7/23/20 revealed: "Client continues to hide her diapers in different places in her room, and attempts not too have staff enter her room, and attempts not too have staff enter her room to find them Client has attempted to destroy group home property several times within the past month. Client has attempted to destroy group home property several times within the past month. Client has thrown a chair and has punched the wail on multiple occasions. Client has an outburst when she is not allowed to go to the store," -Discharge Summary dated 8/6/20 written by Licensee #1/Director/Qualified Professional #1 revealed explosive behaviors with foul language, aggression twice weekly, communicating threats, urinating on self, and destroying property; -Treatment Plan update dated 7/20 revealed 	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
the QP (Qualified Professional). She also stated she wants to kill her mother. She told the QP that she was going to chock him with a knife. She told me that she is going to kill me. She attacked a client as well earlier this week." Interviews on 8/13/20 and 9/1/20 with Former Client #1 revealed: -Recalled running away from the facility at least twice. Review on 8/11/20, 8/12/20 and 8/18/20 of Former Client #2's record revealed: -Admitted 4/16/19; -Discharged 8/6/20; -Discharged 8/6/20; -Discharged 8/6/20; -Treatment plan progress update dated 7/23/20 revealed: "Client continues to hide her diapers in different places in her room to find them Client has attempted to destroy group home property several times within the past month. Client has attempted to destroy group home property several times within the past month. Client has therown a chair and has punched the wall on multiple occasions. Client has an outburst when she is not allowed to go to the store," -Discharge Summary dated 8/6/20 written by Licensee #1/Director/Qualified Professional #1 revealed explosive behaviors with foul language, aggression twice weekly, communicating threats, urinating on self, and destroying property; -Treatment Plan update dated 8/7/20 revealed	V 366	Continued From page	e 91	V 366			
store;" -Discharge Summary dated 8/6/20 written by Licensee #1/Director/Qualified Professional #1 revealed explosive behaviors with foul language, aggression twice weekly, communicating threats, urinating on self, and destroying property; -Treatment Plan update dated 8/7/20 revealed		the QP (Qualified Proshe wants to kill her is she wants to kill her is me that she is going client as well earlier to Interviews on 8/13/20 Client #1 revealed: -Recalled running aw twice. Review on 8/11/20, 8 Former Client #2's re -Admitted 4/16/19; -Discharged 8/6/20; -Diagnosed with Inter Intellectual Developm Spectrum Disorder, I Speech and Languag -15 years old; -Treatment plan prog revealed: "Client of in different places in too have staff enter h Client has attempted property several time Client has thrown a c wall on multiple occa	ofessional). She also stated mother. She told the QP that ock him with a knife. She told to kill me. She attacked a this week." 0 and 9/1/20 with Former way from the facility at least 8/12/20 and 8/18/20 of ecord revealed: rmittent Explosive Disorder, nental Disability Mild, Autism Developmental Disorder of ge; gress update dated 7/23/20 continues to hide her diapers her room, and attempts not her room to find them to destroy group home es within the past month. chair and has punched the asions. Client has an				
		-Discharge Summary Licensee #1/Director revealed explosive b aggression twice we urinating on self, and	/Qualified Professional #1 ehaviors with foul language, ekly, communicating threats, I destroying property;				
Former Client #2 punched 3 holes in the walls.		-					

STATEMENT	of Health Service Regu TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC	837 LYN	HAVEN DRIVE			
		GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 366	Continued From page	e 92	V 366			
	Former Client #3's re -Admitted 4/15/20; -Discharged 8/6/20; -Diagnosed with Opp -17 years old; -Discharge Summary Licensee #1/Director, revealed incidents of Review on 8/11/20, 8 Former Client #4's re -Admitted 4/15/20; -Discharged 8/6/20; -Discharged 8/6/20; -Discharge Summary #1/Director/Qualified revealed incidents of aggression weekly. Requests to the Licen Professional #1 and 1 Director for all incident 8/10/20 at approximation and on 8/10/20 at 111 10:17am via email co Review on 8/13/20 of from 7/1/20 - 8/7/20 r -Only one incident re Former Client #1; -No incident reports w Clients #2, #3, and #4	Accord revealed: Accord revealed: Accord revealed: A dated 8/6/20 written by /Qualified Professional #1 physical aggression weekly. A/12/20 and 8/18/20 of Accord revealed: Accord revea				
	Professional #2 and I Director for the Incide made on 9/10/20 at 1 correspondence. Lic	Licensee #2/Executive ent Reporting Policy was				

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING	09	9/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEI	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From page	e 93	V 366			
	request.					
	sent by Licensee #1/ Professional #2 rever - "In regard to your information (including we can provide when week. It is my under #2/Executive Directo several times during determine what you ne verything without de be a delay now being town. I hope you und Review on 9/15/20 of by the Licensee #2/E at 8:12pm revealed: -"I reached out to you inform you that we w afternoon in order go requested (including could not reach you se Health Service Regu	aled: r request for the other g Incident Reporting Policy), n we return to Charlotte next standing that [Licensee r] has reached out to you this investigation in order to needed so you would have elay. Unfortunately there will g that both of us are out of derstand." f email correspondence sent Executive Director on 9/14/20 u several times today to ill return to work later this n/ get you the information you Incident Reporting Policy). I so I contacted [Division of lation (DHSR) Western order to get clarification on				
	telephone upon return being off from 9/15/2 calls from the License were received on 9/1 at 2:02pm with no vo	f the DHSR's surveyor's in of the DHSR surveyor from 0 - 9/17/20 revealed two ee #2/Executive Director 4/20. One call was received icemail message being left eived on 3:33pm with a sall.				
	Review on 9/18/20 of Incident Reporting Po alth Service Regulation	f the facility's undated olicy revealed:				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-331	B. WING		09	0/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
BRIGHTE	R DAYZ LLC		IHAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From pag	e 94	V 366			
	Form, within twenty-f an incidentis def not consistent with the facility or the routine -Level II incident report IRIS (North Carolina Improvement System Interviews on 9/2/20 Staff #12 revealed: -Worked at the facilit -Clients from the facilit -Con 7/6/20 during he she was working alou Former Client #A3 w up Former Clients #A from camp. After pic camp, a fight ensued five clients while Forn Former Staff #12 call was readily available best she could to ma evening at 11:18pm, phone call from Licer Professional #1 and Director and was tolco line and were investion Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment regard reports. This deficiency is cro	pproved incident Report four hours of the incident ined as any event which is he routine operation of the care of a client" orts will be completed in NC Incident Response n) within 24 hours. and 9/22/20 with Former y and Sister Facility A; lity and Sister Facility A often ent time together; r last shift at Sister Facility A ne. She was asked to take ith Former Client #2 to pick A1 and #A4 and Client #1 exing up the clients from I in the van which involved all mer Staff #12 was driving. led for assistance, but none e. Former Staff #12 received a nsee #1/Director/Qualified Licensee #2/Executive d they were on a recorded gating Former Staff #12. with Licensee Professional #1 and				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL036-331	B. WING		09	/29/2020
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RIGHTE	R DAYZ LLC					
			NIA, 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 367	27G .0604 Incident R	eporting Requirements	V 367			
	level II incidents, exce the provision of billab consumer is on the pri- incidents and level II to whom the provider 90 days prior to the in- responsible for the ca- services are provided becoming aware of the be submitted on a for Secretary. The report in person, facsimile o means. The report st information: (1) reporting pri- identification informati (2) client identifi (3) type of incide (4) description (5) status of the cause of the incident; (6) other individed or responding. (b) Category A and B missing or incomplete shall submit an updat report recipients by the day whenever: (1) the provided erroneous, misleading (2) the provider	REMENTS FOR PROVIDERS Providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within acident to the LME tchment area where within 72 hours of e incident. The report shall m provided by the t may be submitted via mail, r encrypted electronic hall include the following ovider contact and ion; fication information; lent; of incident; e effort to determine the and luals or authorities notified providers shall explain any e information. The provider ed report to all required le end of the next business t has reason to believe that				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
			B. WING				
		MHL036-331			09	/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 367	Continued From page	e 96	V 367				
	 (c) Category A and E upon request by the I obtained regarding the (1) hospital reconstruction; (2) reports by construction; (3) the provider (2) reports by construction; (3) the provider (3) the provider (4) Category A and E of all level III incident Mental Health, Development of the providers shall send a incidents involving a Generation of the provider shall send a incident involving a Generation (1) the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (2) restrictive in the definition of a level III (3) searches of (4) seizures of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construction the total number of the possession of a construc	B providers shall submit, _ME, other information the incident, including: tords including confidential other authorities; and r's response to the incident. B providers shall send a copy reports to the Division of opmental Disabilities and rvices 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 ven days of use of seclusion der shall report the death ired by 10A NCAC 26C C 27E .0104(e)(18). B providers shall send a a LME responsible for the e services are provided. Jubmitted on a form provided electronic means and shall ormation as follows: errors that do not meet the or level III incident; therventions that do not meet tel II or level III incident; f a client or his living area; client property or property in dient; mber of level II and level III ed; and t indicating that there have					

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STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
BRIGHTEI	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 367	Continued From page	e 97	V 367			
	(a) and (d) of this Rul through (4) of this Pa	le and Subparagraphs (1) iragraph.				
	failed to report all Lev (local management e	nd record review, the facility vel II incidents to the LME entity) responsible for the re services are provided coming aware of the				
	Former Client #1's re -Admitted 7/19/20; -Discharged 8/5/20; -Diagnosed with Posi Attention Deficit Hype Mood Dysregulation -13 years old;	t-Traumatic Stress Disorder, eractivity Disorder, Disruptive Disorder; Residential Application				
	Response Improvem period 7/1/20 - 8/25/2 -No incident reports f -Searched website by	for period 7/1/20 - present; y county, facility name, each client name. No				
		f email correspondence en DHSR surveyor and NC				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL036-331			09	/29/2020
IAME OF PF	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTEF	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE COM D THE APPROPRIATE	
V 367	Continued From page 98		V 367			
	IRIS but was not sub -The incident involve 7/27/20; -"The client became instructions to complet threatened to runawa harm herself. Client a but all scissors have only at request. Client lamp to electrocute h lamp before client ma attempted to use the herself. Staff held the to prevent the client f became upset, threw then ran to her room. television, went to the her jumping out the v window behind the cl neighbors home clain that was following he the police being unaw stayed back to not st EMT. Staff requested allow the client in his wait for the police. El them and informed th Client was transporte Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment regard reports.	d Former Client #1 on non-compliant with staff ete her daily journal. Client ay from the facility and to attempted to locate scissors been locked up and used at made an attempt to lick a erself. Staff unplugged the ade contact. The client cord from the lamp to choke e onto the cord from the lamp rom harming herself. Client the television on the floor, . Staff picked up the e clients room and observed window. Staff jumped out the lient. Client ran to a ming to not know the staff r. Neighbor decided to call ware of the situation. Staff artle the neighbor and called that the neighbor did not home and suggested we all MT arrived and staff updated nem of the suicidal ideations. ed to the hospital."				
	This deficiency is cro	ss referenced into 10A				

STATEMENT	of Health Service Regu of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		MHL036-331	B. WING		09/29/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		837 LYN	HAVEN DRIVE			
BRIGHTEI	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX				PROVIDER'S PLAN OF		(X5) COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO DEFICIEN		DATE
V 367	Continued From page 99		V 367			
	NCAC 27G .1701 Sc rule violation.	ope (V293) for a Type A1				
V 536	27E .0107 Client Rig Int.	nts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclu- employees, students demonstrate compete completing training in other strategies for cr which the likelihood cr or injury to a person of property damage is p (c) Provider agencies based on state comp compliance and demo gathered. (d) The training shall include measurable left measurable testing (to behavior) on those of methods to determine course. (e) Formal refresher	RESTRICTIVE plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully a communication skills and reating an environment in of imminent danger of abuse with disabilities or others or revented. s shall establish training etencies, monitor for internal onstrate they acted on data be competency-based, earning objectives, written and by observation of ojectives and measurable e passing or failing the training must be completed der periodically (minimum				
	the Division of MH/DI Paragraph (g) of this	•				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		00/00/0000		
NAME OF PR	OVIDER OR SUPPLIER	l	B. WING 09/29/2020 T ADDRESS, CITY, STATE, ZIP CODE 09/29/2020				
			HAVEN DRIVE	,			
BRIGHTER	DAYZ LLC	GASTO	NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE	
V 536	Continued From page	e 100	V 536				
	people being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with per (5) recognizing organizational factors disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in ass escalating behavior; (8) communica and de-escalating pot and (9) positive beh means for people with activities which direct behaviors which are u (h) Service providers documentation of initi at least three years. (1) Documenta (A) who particip outcomes (pass/fail); (B) when and v (C) instructor S (2) The Division review/request this do (i) Instructor Qualifica Requirements: (1) Trainers sha	and interpreting human the effect of internal and at may affect people with or building positive sons with disabilities; cultural, environmental and a that may affect people with the importance of and n's involvement in making life; essing individual risk for tion strategies for defusing tentially dangerous behavior; navioral supports (providing h disabilities to choose ly oppose or replace unsafe). s shall maintain fal and refresher training for tion shall include: uated in the training and the where they attended; and name; n of MH/DD/SAS may pocumentation at any time.					

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-331	B. WING 09/29/2020			
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From page	e 101	V 536			
	need for restrictive in (2) Trainers shi by scoring a passing instructor training pro- (3) The training competency-based, i objectives, measurable observation of behave measurable methods failing the course. (4) The conten- service provider plan approved by the Divi- to Subparagraph (i)(5) (5) Acceptable shall include but are (A) understand (B) methods for course; (C) methods for performance; and (D) documentar (6) Trainers shi teaching a training pur reducing and elimina interventions at least review by the coach. (7) Trainers shi aimed at preventing, need for restrictive in annually. (8) Trainers shi instructor training at 1 (j) Service providers documentation of init training for at least the (1) Docum	all demonstrate competence grade on testing in an ogram. g shall be nclude measurable learning ble testing (written and by itor) on those objectives and a to determine passing or a to determine passing or b of this Rule. a instructor training programs a passing the need for restrictive one time, with positive a ll teach a training program reducing and eliminating the terventions at least once a ll complete a refresher least every two years. a shall maintain a and refresher instructor				

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		09/29/2020		
NAME OF P	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE, ZIP CODE				
BRIGHTE	R DAYZ LLC		HAVEN DRIVE				
			NIA, NC 28052				
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 536	outcomes (pass/fail); (B) when and v (C) instructor's (2) The Divisio request and review th (k) Qualifications of (1) Coaches sh requirements as a tra (2) Coaches sh the course which is b (3) Coaches sh competence by comp train-the-trainer instru	where attended; and name. n of MH/DD/SAS may nis documentation any time. Coaches: nall meet all preparation ainer. nall teach at least three times being coached. nall demonstrate oletion of coaching or	V 536				
	failed to ensure staff to restrictive interven audited staff member are: Attempted review on #6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	nd record review, the facility were trained in alternatives tions affecting 1 of 10 rs (Staff #6). The findings 9/4/20 and 9/8/20 of Staff successful as no records for review. Requests for the nt to Licensee Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be					

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STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 536	Continued From page	e 103	V 536			
	revealed: -Not a good time for a was working at her of -"I start my Brighter I after so call me at 2(p Attempted interview 9 #6 was unsuccessful the mailbox was full. the phone 2:11pm wh series of text messag DHSR surveyor contri informed she would b Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executiv -No comment. This deficiency is cro	Dayz (Licensee/Facility) shift om)." D/11/20 at 2:10pm with Staff . There was no answer and A text message was sent to nich was read at 2:12pm. A les between Staff #6 and the nued and Staff #6 was be contacted as needed. with Licensee Professional #1 and				
V 537	ITO 10A NCAC 27E .010 SECLUSION, PHYSI ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to em procedures are retrai competence at least	CAL RESTRAINT AND JT cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that apploy and terminate these ned and have demonstrated	V 537			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-331	B. WING		00	09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	03	5/25/2020	
			HAVEN DRIVE	,			
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 537	Continued From page	e 104	V 537				
	 includes restrictive in service providers, envolunteers shall completed seclusion, physical reand shall not use the training is completed demonstrated. (c) A pre-requisite for demonstrating completed demonstrating completed demonstrating completed demonstrating in preventing the need for restrictive (d) The training shall include measurable testing (whether the second secon	plete training in the use of estraint and isolation time-out se interventions until the and competence is r taking this training is etence by completion of , reducing and eliminating re interventions. be competency-based, earning objectives, written and by observation of bjectives and measurable e passing or failing the training must be completed ider periodically (minimum ining that the service bloy must be approved by D/SAS pursuant to Rule. ng programs shall include, presentation of: formation on alternatives to interventions; on when to intervene hent danger to self and on safety and respect for the all persons involved (using trictive interventions and an intervention); or the safe implementation					

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09	9/29/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			,0,00
		837 LYN	HAVEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
V 537	Continued From page	e 105	V 537			
	psychological well-be use of restraint throug restrictive intervention (6) prohibited p (7) debriefing s importance and purpe (8) documenta (h) Service providers documentation of init at least three years. (1) Documenta (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Divisio review/request this de (i) Instructor Qualific Requirements: (1) Trainers sh by scoring 100% on t aimed at preventing, need for restrictive in (2) Trainers sh by scoring 100% on t teaching the use of s and isolation time-ou (3) Trainers sh by scoring a passing instructor training pro- (4) The training competency-based, i objectives, measurab observation of behav measurable methods failing the course.	hitoring of the physical and being of the client and the safe ghout the duration of the n; procedures; strategies, including their ose; and tion methods/procedures. shall maintain ial and refresher training for tion shall include: bated in the training and the where they attended; and name. n of MH/DD/SAS may ocumentation at any time. ation and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. all demonstrate competence testing in a training program eclusion, physical restraint t. all demonstrate competence grade on testing in an ogram.				

Division of Health Service Regulation STATE FORM

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-331	B. WING		09/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	l	DDRESS, CITY, STATE,			//25/2020
			HAVEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTON	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	e 106	V 537			
	service provider plans approved by the Divis to Subparagraph (j)(6 (6) Acceptable shall include, but not of: (A) understandii (B) methods for course; (C) evaluation of (D) documentat (7) Trainers sha annually and demons of seclusion, physical time-out, as specified Rule. (8) Trainers sha corer. (9) Trainers sha in teaching the use of least two times with a coach. (10) Trainers sha use of restrictive inter annually. (11) Trainers sha instructor training at least (k) Service providers documentation of initi training for at least the (1) Documenta (A) who particip outcome (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this do (I) Qualifications of C	s to employ shall be sion of MH/DD/SAS pursuant b) of this Rule. instructor training programs be limited to, presentation ing the adult learner; r teaching content of the of trainee performance; and ion procedures. all be retrained at least strate competence in the use restraint and isolation in Paragraph (a) of this all be currently trained in all have coached experience f restrictive interventions at in positive review by the all teach a program on the ventions at least once all complete a refresher east every two years. is shall maintain al and refresher instructor ree years. tion shall include: vated in the training and the where they attended; and name. in of MH/DD/SAS may pocumentation at any time.				

STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-331	B. WING		09	/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	times, the course whi	ainer. nall teach at least three ich is being coached. nall demonstrate oletion of coaching or uction. shall be the same	V 537			
	failed to ensure staff physical restraint and	as evidenced by: nd record review, the facility were trained in seclusion, I isolation time-out affecting members (Staff #6). The				
	#6's records was uns were made available staff records were se #1/Director/Qualified Licensee #2/Executiv 9:53am for the record	Professional #1 and ve Director on 9/4/20 at ds to be sent via fax and 34pm for the records to be				
	revealed: -Not a good time for a was working at her o	Dayz (Licensee/Facility) shift				
ision of U.	#6 was unsuccessful	9/11/20 at 2:10pm with Staff . There was no answer and A text message was sent to				

Division of Health Service Regi STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
AME OF PF	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE HAVEN DRIVE	ZIP CODE	
RIGHTER	R DAYZ LLC		NA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE COMPLETE D THE APPROPRIATE DATE		
V 537	Continued From page 108		V 537				
	series of text messag DHSR surveyor cont informed she would Interview on 9/25/20 #1/Director/Qualified Licensee #2/Executi -No comment.	hich was read at 2:12pm. A ges between Staff #6 and the inued and Staff #6 was be contacted as needed. with Licensee Professional #1 and ve Director revealed: oss referenced into 10A cope (V293) for a Type A1					