STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIGHTER DAYZ LLC	837 LYNHAVEN DRIVE GASTONIA, NC 28052

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 4/16/21 as a result of the request of the licensees informal conference meeting held on 12/2/20. The complaint was unsubstantiated (Intake #NC173223). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.	V 109		

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V 109	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on interview, record review, and observation, 1 of 2 audited qualified professionals (Licensee #1/Director/Qualified Professional #1) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 3/17/21 of Licensee #1/Director/Qualified Professional #1's record revealed: -Hire date of 2/1/18; -Was retrained in First Aid, Cardiopulmonary Resuscitation, Bloodborne Pathogens, Medication Administration, Seizure Management, Mental Health/Developmental Disabilities/Substance Abuse Services, Client Specific Trainings, Alternatives to Restrictive Intervention, Seclusion, Physical Restraint, and Isolation Time-Out, Orientation, Rights and Confidentiality, Population Served, Documentation, Crisis Planning and Management, Person Centered Planning, Health and Safety, Cultural Competency, Sexually Aggressive Youth, and Incident Response	V 109		

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V 109	Continued From page 2 Improvement System during October, 2020. Review on 4/1/21 of Licensee #1/Director/Qualified Professional #1's Job Description revealed: -Job description signed by Licensee #1/Director/Qualified Professional #1 dated 2/1/18 revealed job responsibilities included " ...supervision of the associate professionals and para-professionals, oversight of emergencies, provision of direct psycho educational services to children or adolescents, participation in treatment planning meetings, coordination of each child or adolescent's treatment plan, provision of basic case management functions ..." Review on 3/18/21 of the Statement of Deficiencies completed as a result of 9/29/20 Division of Health Service Regulation (DHSR) survey revealed: -Licensee #1/Director/Qualified Professional #1 was cited for failure to demonstrate the knowledge, skills, and abilities required by the population served; -Plan of Protection dated 9/29/20 written and signed by Licensee #1/Director/Qualified Professional #1 revealed: " ...will comply with all requirements of 10A NCAC 27G .0203 including ensuring the competency of the Qualified Professional. Specifically, the Qualified Professional will receive training by a qualified trainer by 10/18/20: technical knowledge; cultural awareness; analytical skills; decision-making; interpersonal skills; communication skills; and clinical skills ..." Review on 3/18/21 of the Plan of Correction completed in response to the 9/29/20 DHSR survey with targeted correction completion date of 10/22/20 revealed:	V 109		

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V 109	Continued From page 3 -" ...The agency will comply with all requirements of 10A NCAC 27G .0203 including ensuring the competency of the Qualified Professional. Specifically, the Qualified Professional will receive training by a qualified trainer in: 1. technical knowledge, 2. cultural awareness, 3. analytical skills, 4. decision-making, 5. interpersonal skills, 6. communication skills, and 7. clinical skills. In addition the Qualified Professional will be trained by a qualified instructor in 1. cultural competency, 2. client rights and confidentiality, 3. crisis management and planning, 4. person-centered planning conducting admission assessments. To ensure compliance with standards around ...person-centered planning the agency's Licensed Mental Health Professional will review and approve all ...person-centered plans prior to implementation. The plans will be reviewed for completeness and clinical appropriateness ..." Review on 2/15/21 of Client #1 record revealed: -December 2020, January2021 and February 2021 MARs (medication administration records) were not kept current making it impossible to determine if medications were administered as ordered (Refer to 10A NCAC 27G .0209 Medication Requirements (V118) for specifics. Review on 2/15/21 of Former Client #2's record revealed: -Former Client #2's treatment plan dated 5/1/20 revealed no strategies for AWOL (absent without leave) or methods of ensuring supervision when away from the facility despite the client's history and job placement. Attempted review on 2/15/21 of the facility's Internal Investigations revealed there were no Internal Investigations.	V 109		

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V 109	Continued From page 4 Review on 2/15/21 of the facility's Incident Reports revealed: -There was no Level III incident report completed regarding the allegation of Former Staff #5 offering marijuana to Former Client #2. Interview on 2/17/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was responsible for developing the treatment plan goals and strategies. -Not sure why there are missing medications on Client #1's medications administration records; -Would need to ask the House Manager regarding the lack of notation of medication administration for Client #1; -The House Manager was responsible for overseeing the MARs; -It was not his responsibility to ensure dead bug carcasses were cleaned from the window; -It was an oversight that the window was not repaired. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was responsible for developing treatment plan goals and strategies; -Dead bugs on the windowsills are the responsibility of the landscapers after the pest control company came to the facility to treat a hornet's nest; -Not sure how the window in Former Client #2's bedroom broke; -Had originally reported the broken window to the repair shop around January, 2021 and did not follow up regarding the broken window; -Did not follow up regarding the broken window until DHSR surveyors were present and then followed up and the window was repaired the next day (2/18/21). -Denied Department of Social Services initiated	V 109		

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V 109	Continued From page 5	V 109		

an investigation at the facility;
-Denied having to complete an internal investigation or notification to Health Care Personnel Registry regarding the allegations brought forward by DSS regarding Former Staff #5 offering marijuana a to Former Client #1;
-The reason behind missing medications on Client #1's medication administration records was " ...human error ..."

Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 during the survey exit meeting revealed:
-Not sure why Licensee #2/Executive Director's most current certificate for training in Nonviolent Crisis Intervention was not provided but the training was completed in October, 2020.

Observation on 2/15/21 at approximately 11:30am of the facility revealed:
-Broken window in bedroom #1 (Former Client #2's bedroom). The broken windowpane was on 6 pane-window, three over three, and the one pane which was broken was the middle pane on the bottom half of the window. The hole in the windowpane was approximately a four inch diameter hole with jagged edges of plexiglass. The 6 pane window was on the interior of the room and was backed by a solid glass storm window which was intact.

Observation on 2/15/21 at approximately 11:30am of the front of the facility revealed:
-Numerous insect carcasses in the windowsills of the two front windows furthest from the front door overlooking the front porch;
-The insect carcasses appeared similar to a beetle.

This deficiency constitutes a recited deficiency,

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V 109	Continued From page 6 previously cited 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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This Rule is not met as evidenced by:
Based on interview, record review, and observation, 1 of 7 audited paraprofessionals (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:

Review on 3/17/21 of Licensee #2/Executive Director's record revealed:
-Hire date of 2/1/18.
-Was retrained in First Aid, Cardiopulmonary Resuscitation, Bloodborne Pathogens, Medication Administration, Seizure Management, Mental Health/Developmental Disabilities/Substance Abuse Services, Client Specific Trainings, Rights and Confidentiality, Population Served, Crisis Planning and Management, Health and Safety, Plan of Correction, Documentation, Person Centered Planning, Cultural Competency, Security and Accessibility of Records, Sexually Aggressive Youth, and Incident Response Improvement System during October, 2020.

Review on 4/1/21 of Licensee #2/Executive Director's Job Description revealed:
-Job description signed by the Licensee #2/Executive Director dated 2/3/18 revealed job responsibilities included " ...HR (human resources) records, client records, intake process, MARs (medication administration records) planning outing, filing reports, authorizations, communicate directly with MCO/LME (managed care organizations/local

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management entities), DSS (Department of Social Services), (DHSR (Division of Health Service Regulation), legal guardian, DJJ (Department of Juvenile Justice), etc. schedule trainings, oversee financial management, develop budgets, evaluate performance, handle conflict with staff and client, assist with discharge process, Etc.: performing different task that can vary by setting ..."

Review on 3/18/21 of the Statement of Deficiencies completed as a result of 9/29/20 Division of Health Service Regulation (DHSR) survey revealed:
-Licensee #2/Executive Director was cited for failure to demonstrate the knowledge, skills, and abilities required by the population served;
-Plan of Protection written and signed by Licensee #1/Director/Qualified Professional #1 revealed: " ...will comply with all requirements of 10A NCAC 27G .0204 including ensuring the competency of the para professionals. Specifically, newly hired and returning para professionals will receive training by a qualified trainer prior to starting work: technical knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills, and clinical skills ..."

Review on 2/15/21 of Client #1's record revealed:
-December 2020, January 2021 and February 2021 MARs (medication administration records) were not kept current making it impossible to determine if medications were administered as ordered (Refer to 10A NCAC 27G .0209 Medication Requirements (V118) for specifics.

Review on 2/15/21 of Former Client #2's record revealed:
-Former Client #2's treatment plan dated 5/1/20

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V 110	Continued From page 9	V 110		

revealed no strategies for AWOL (absent without leave) or methods of ensuring supervision when away from the facility despite the client's history and job placement.

Attempted review on 2/15/21 of the facility's Internal Investigations revealed there were no Internal Investigations.

Review on 2/15/21 of the facility's Incident Reports revealed:
-There was no Level III incident report completed regarding the allegation of Former Staff #5 offering marijuana to Former Client #2.

Interview on 3/31/21 with Licensee #2/Executive Director revealed:
-Responsible for house inspections monthly and "walks around the house and looks around;"
-Responsible for " ...checking behind the house manager ...;"
-The House Manager completed the house inspections and Licensee #2/Executive Director checked behind the House Manager;
-When asked to clarify who completed house inspections, the question was not answered;
-"Maybe we can spray with lye (when discussing the multiple insect carcasses in the windowsills);"
-Denied Department of Social Services initiated an investigation at the facility;
-Denied having to complete an internal investigation or notification to Health Care Personnel Registry regarding the allegations brought forward by DSS regarding Former Staff #5 offering marijuana a to Former Client #1;
-When asked why Client #1's medications were not listed on the MARs she revealed "..I don't know why it wasn't on there honestly ...maybe there was a new medication subtracted and then added back on ..."

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V 110	Continued From page 10 -Repair of the window in Former Client #2's bedroom was delayed because it "slipped through the cracks" and the repairman did not come out . Interviews on 4/8/21 with Licensee #2/Executive Director during the survey exit meeting revealed: -Not sure why Licensee #2/Executive Director's most current certificate for training in Nonviolent Crisis Intervention was not provided but the training was completed in October, 2020. Observation on 2/15/21 at approximately 11:30am of the facility revealed: -Broken window in bedroom #1 (Former Client #2's bedroom). The broken windowpane was on 6 pane-window, three over three, and the one pane which was broken was the middle pane on the bottom half of the window. The hole in the windowpane was approximately a four inch diameter hole with jagged edges of plexiglass. The 6 pane window was on the interior of the room and was backed by a solid glass storm window which was intact. Observation on 2/15/21 at approximately 11:30am of the front of the facility revealed: -Numerous insect carcasses in the windowsills of the two front windows furthest from the front door overlooking the front porch; -The insect carcasses appeared similar to a beetle. This deficiency constitutes a recited deficiency, previously cited 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 110		

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V 112	Continued From page 11	V 112		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement strategies to address the needs of the clients affecting 1 of 1 audited former client (Former Client #2). The	V 112		

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V 112	Continued From page 12 findings are: Review on 2/15/21 of Former Client #2's record revealed: -Admitted 10/15/20; -AWOL (absent without leave) 12/20/20; -Discharged 12/30/21 as a result of not returning to facility after the 12/20/20 AWOL; -17 years old; -History of repeated AWOL, impaired judgement, risky community behaviors, substance abuse, and sex trafficking; -Job placed at a local fast food restaurant within weeks of admission to the facility with no assessment to determine the ability to work unsupervised; -Treatment plan dated 5/21/20 revealed: -no goal or strategies to address employment; -no strategies for AWOL or methods of ensuring supervision when away from the facility despite the client's history and job placement; -Treatment plan update 12/3/20 revealed: ..."The client has done well at the placement and continues to work at [local fast food restaurant] ..." Review on 3/8/21 of email correspondence dated 3/8/21 from Former Client #2's Department of Social Services (DSS) Legal Guardian revealed: -"Here is the information you requested regarding [Former Client #2] from our 2.24.21 court report: 'It was reported to the group home staff by the employer, that the week prior to her running away, [Former Client #2] had been living work and getting into a car with an unknown individual. She was returning to work prior to the group home staff picking her up. The group home was also informed that [Former Client #2] had been in possession of a cell phone ...'"	V 112		

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V 112	Continued From page 13 Attempted interviews with Former Client #2 were unsuccessful as Former Client #2 was still missing after going AWOL from the facility on 12/20/20. Messages were left with Former Client #2's DSS Social Worker and Former Client #2's mother on 2/15/21 and 3/3/21 requesting a call if Former Client #2 was located. No call was ever received. Interview on 3/3/21 with Former Client #2's DSS Legal Guardian revealed: -Former Client #2 was on AWOL status since December, 2020 after leaving the facility; -Former Client #2 had a significant history of AWOL and had eloped in early October, 2020 from a Level IV facility with a peer. When located, the peer reported Former Client #2 met a man at a local superstore and had sex with him for money but Former Client #2 denied the allegation; -The staff from the fast food restaurant where Former Client #2 worked reported Former Client #2 left work and got into a car with an unknown male and returned to the fast food restaurant just prior to the facility staff arriving to pick her up from work. Interview on 2/15/21 with Former Client #2's DSS Legal Guardian's Supervisor revealed: -Former Client #2 went AWOL from the facility in December, 2020 and had still not been located; -Former Client #2 was in touch with her DSS Legal Guardian from a blocked number while AWOL; -Former Client #2 was employed at a local fast food restaurant while receiving treatment from the facility; -Former Client #2 was leaving her place of employment after being dropped off by the facility	V 112		

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staff and getting into a car with an unknown male. This was reported by Former Client #2's place of employment to Licensee #2/Executive Director who then reported the information to the DSS office.

Interview on 3/3/21 with Former Client #2's Department of Juvenile Justice Worker revealed:
-Former Client #2 was on AWOL status and was in contact with her mother and told her mother she will not return until she turns 18 years old.

Attempted interviews on 3/3/21 and 3/22/21 of the management team of the local fast food restaurant where Former Client #2 was employed were unsuccessful. Nobody was available to answer questions regarding Former Client #2's employment and phone calls to the local fast food restaurant were unanswered with no option of leaving a voicemail message.

Interview on 3/8/21 with Staff #1 revealed:
-It was not necessary to check on Former Client #2 once she was at work at the local fast food restaurant;
-Facility staff started " ...popping into [local fast food restaurant] to check on her (Former Client #2) ..." after it was reported that there was suspicious activity of Former Client #2 leaving work with an unidentified individual.

Interview on 3/23/21 with Staff #2 revealed:
-Former Client #2 had a history of AWOL;
-Former Client #2 worked at a local fast food restaurant;
-Would pick Former Client #2 up from work sometimes.

Interview on 3/9/21 with Staff #3 revealed:
-Former Client #2 worked at a local fast food

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restaurant;
-Former Client #2 had to be picked up from work on some shifts;
-There was no need to visit Former Client #2 or check on her while she was at work;
-Former Client #2 would call the facility if she got sick or got off work early.

Interview on 3/3/21 with Former Staff #4 revealed:
-Left her employment with the facility because she was not comfortable with the way Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director ran the facility;
-Former Client #2 had a job at a local fast food restaurant and used to leave work;
-Former Staff #4 did not have any specific information about Former Client #2 leaving work as it happened prior to Former Staff #4's hire date (11/19/20);
-Facility staff started to get print-outs of Former Client #2's work schedule at the local fast food restaurant so they could confirm when Former Client #2 needed to be at work;
-Facility staff did not walk Former Client #2 into work but dropped her off and picked her up in front of the restaurant;
-Facility staff did not have to go to the local fast food restaurant to check on Former Client #2.

Interview on 3/9/21 with the Associate Professional revealed:
-Former Client #2 worked at a local fast food restaurant;
-Former Client #2 was dropped off and picked up from her shift by staff;
-No need to go to the local fast food restaurant to check on Former Client #2 during her shifts;
-Did not have any knowledge of Former Client #2 leaving her shifts to get into a car with an

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V 112	Continued From page 16 unidentified individual. Interview on 3/22/21 with the House Manager revealed: -Did not know anything about Former Client #2 leaving her shift at a local fast food restaurant with an unidentified individual. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional revealed: -Former Client #2 had a job at a local fast food restaurant and the facility was " ...written up (by DHSR on 11/13/20) because it was not in her treatment plan ...;" -Staff transported Former Client #2 to work; -Former Client #2 was monitored while at work with staff calling and driving by work both announced and unannounced because the local fast food restaurant was in close proximity to the group home; -Licensee #2/Executive Director was notified that Former Client #2 was leaving her place of employment with an unidentified male and Licensee #2/Executive Director notified Licensee #1/Director/Qualified Professional #1; -Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director were notified of Former Client #2 leaving work with an unidentified man 2 days prior to her going AWOL (12/20/20) so they scheduled an emergency team meeting; -Former Client #2 denied leaving work when questioned y Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director; -Staff told Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director that Former Client #2 was always present when the staff checked on her at the restaurant.	V 112		

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V 112	Continued From page 17 Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Former Client #2 had a job at a local fast food restaurant and had a treatment plan goal to address the employment; -Staff checked on Former Client #2 every two to three hours when she worked as the local fast food restaurant was not far from the facility; -Staff may have also called Former Client #2 on the phone sometimes when she was at work; -Was informed Former Client #2 was leaving work with an unidentified male two days before Former Client #2 went AWOL (12/20/20) so Licensee #2/Executive Director scheduled an emergency team meeting and Former Client #2 did not return to work; -Could not recall who reported Former Client #2 was leaving work with an unidentified male. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director during the exit meeting. This deficiency constitutes a recited deficiency, previously cited 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 112		
V 118	27G .0209 (C) Medication Requirements	V 118		

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V 118	Continued From page 18 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure	V 118		

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V 118	Continued From page 19 medications were administered as ordered by the physician affecting 1 of 1 current client (Client #1). The findings are: Review on 2/15/21 and 3/16/21 of Client #1's record revealed: -Admitted 10/15/20; -Diagnosed with Intermittent Explosive Disorder, Intellectual Developmental Disability - Mild, Autism, Language Disorder; -16 years old -History of self-injurious behaviors, property destruction, and physical aggression requiring assistance of local law enforcement; -Physician's orders dated 2/3/21 for Desmopressin (urinary incontinence) 0.2mg 2 tabs (tablets) hs (hour of sleep), Melatonin (sleep aid) 10mg 2 caps (caplets) hs, Aripiprazole (antipsychotic used for irritability associated with autism) 10mg 1 tab daily, and Stool Softener 100mg 1 cap daily; -Physician's order dated 2/21/21 to discontinue Aripiprazole 10mg 1 tab daily; -December 2020, January 2021, and February, 2021 MARs revealed: -no documentation of administration of Desmopressin on the December, January, and February MARs; -no documentation of administration of Melatonin on the December, January, and February MARs; -no documentation of Aripiprazole on the February MAR; -no documentation of administration of stool softener on 2/2/21. Interview on 3/3/21 with the dispensing Pharmacist revealed: -Client #1 was prescribed Desmopressin since 12/8/20 with additional re-fill dated of 1/5/21 and 2/3/21;	V 118		

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V 118	Continued From page 20 -Client #1 was prescribed Melatonin since 11/9/20 with additional re-fill dates of 12/7/20, 1/5/21, and 2/3/21; -Client #1 was prescribed Aripiprazole since 11/9/20 with additional refill dates of 12/7/20 and 1/5/21; -Did not know if Client #1's Aripiprazole was discontinued; -Provided the option to pre-print the MARs at the pharmacy but the facility was not interested; -" ...They (the facility staff) are not very easy to work with ..." -All medication orders were recently transferred to another local pharmacy. Interview on 3/8/21 with Staff #1 revealed: -Administered medications at the facility; -Not aware of any mistakes or deletions of medications listed on the MARs; -Training is to check the MAR " ...with the prescription with the doctor's order and then check it all against the pills being administered and if there are any discrepancies to call [Licensee #1/Director/Qualified Professional #1] and [House Manager] immediately ..." Interview on 3/9/21 with Staff #3 revealed: -Administered medications as needed; -Never had a problem with MARs missing medications; -Administered medications to clients one client at a time; -" ...Look at the medications and compare it to the MARs to make sure it is the correct medications ..." Interview on 3/3/21 with Former Staff #4 revealed: -Left her employment with the facility because she was not comfortable with the way Licensee	V 118		

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V 118	Continued From page 21 #1/Director/Qualified Professional #1 and Licensee #2/Executive Director ran the facility; -Administered medications at the facility; -Did not remember specifics about the MARs or if Client #1 had any medications missing from the MARs; -" ...Check the person, check the prescriptions, check the MAR because that tells what medications to give, and match the labels to the prescriptions ..." Interview on 3/9/21 with the Associate Professional revealed: -Did not administer medications at the facility. Interview on 2/15/21 with the House Manager revealed: -Not all of Client #1's medications are listed on the MARs for December 2020, January 2021, and February 2021 - "it was a mistake;" -No staff contacted the House Manager during the months of December 2020, January 2021, or February 2021 to report the errors with the MARs. Interview on 3/22/21 with the House Manager revealed: -" ...I messed up the MARs. I am no longer over the MARs. [Licensee #2/Executive Director] is over the MARs. Not even sure what I did ...;" -Was unable to identify if Client #1's medications were administered properly. Interview on 2/17/21 with the Licensee #1/Director/Qualified Professional revealed: -Did not have any information regarding the errors with the MARs; -The House Manager was responsible for overseeing the MARs. Interview on 3/31/21 with the Licensee	V 118		

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V 118	Continued From page 22 #1/Director/Qualified Professional revealed: -The medication administration protocol was to retrieve the medications from a double locked cabinet, wear gloves, get the pharmacy pre-packaged medication packs, peel back the plastic label, hand the plastic receptacle to the clients for the clients to take the medications; -It was " ...human error ..." that all of Client #1's medications were not listed on the MARs; -The House Manager was responsible for ensuring the medications were signed as administered but now the Licensee #2/Executive Director is handling oversight of the MARs; -Believed Client #1 received all of her medications as ordered by the physician because the medications arrived from the pharmacy pre-packaged and the pharmacy filled the orders according to the physician's orders which essentially " ...took the thought out of it (medication administration) ...;" -Licensee #2/Executive Director completed a pill count. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -The medication administration protocol was to wear gloves, take the plastic container the medications arrive from the pharmacy in and peel the back label off, put the medications in the client's mouth, drink water, swallow and allow the staff to check the client's mouth; -When asked why Client #1 medications were not listed on the MARs she revealed "..I don't know why it wasn't on there honestly ...maybe there was a new medication subtracted and then added back on..;" -Believed Client #1 received all of her medications as ordered by the physician because " ...if you look on the back of the pill packs it has all the medications in the pill pack listed ...the	V 118		

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V 118	Continued From page 23 listing on the back matches the listing on the top of the blister pack ..." Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director during the exit meeting. Observation on 2/15/21 at approximately 8:35am of Client #1's medications revealed: -Stool softener 100mg, Desmopressin 0.2 mg, Melatonin 10mg in pharmacy pre-packaged daily blister packs dispensed 2/3/21 Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a recited deficiency, previously cited 9/13/19 and 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of	V 132		

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V 132	Continued From page 24 unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 25 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all allegations against health care personnel, failed to complete an internal investigation and failed to protect clients during the investigation process affecting 1 of 1 audited former staff (Former Staff #5). The findings are: Attempted review on 2/15/21 of the facility's Internal Investigations revealed no Internal Investigations were available for review. Interview on 3/8/21 with the Social Worker from the local Department of Social Services (DSS) revealed: -The local DSS office completed an investigation regarding Former Staff #5 offering marijuana to Former Client #2; -The Social Worker's supervisor investigated the matter but did not have access to Former Client #2 because Former Client #2 was AWOL (absent without leave). Interview on 4/5/21 with the local DSS Supervisor revealed: -Went to the facility on 1/7/21 at 1:30pm to meet with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director to investigate the allegation of Former Staff #5 offering marijuana to Former Client #2; -Spoke with Client #1 on 1/7/21 while at the facility but did not get any significant information as Client #1 was "very limited with verbal skills." Interviews on 2/15/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director revealed: -Were out of the country traveling and were unavailable to come to the facility to meet with	V 132		

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V 132	Continued From page 26 representatives from the Division of Health Service Regulation (DHSR); -There were no Internal Investigations or reports to Health Care Personnel Registry (HCPR) for the facility since the last time DHSR was present for a survey. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Responsible for completing internal investigations at the facility as " ...that is my wheelhouse ...;" -Denied DSS came to the facility regarding an allegation; -DSS only went to a sister facility where an allegation was made regarding a different staff member offering marijuana to a different client. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Licensee #1/Director/Qualified Professional #1 is responsible for completing Internal Investigations for the facility; -Denied there was an allegation of a staff member offering marijuana to Former Client #2; -The allegation of a different staff member offering marijuana to a different client happened at a sister facility. Interviews on 4/8/21 with Licensee #1/Executive Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director. This deficiency is cross-referenced into 10A	V 132		

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V 132	Continued From page 27 NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 132		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the	V 293		

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V 293	Continued From page 28 acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide supervision and structure of daily living, minimize the occurrence of behaviors related to functional deficits, ensure safety and deescalate out of control behaviors, assist in the acquisition of adaptive functioning and gaining the skills needed to step-down to a less intensive treatment setting affecting 1 of 1 current client (Client #1) and 1 of 1 audited former client (Former Client #2). The findings are: CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on interview, record review, and observation, 1 of 2 audited qualified professionals (Licensee #1/Director/Qualified Professional #1) failed to demonstrate the knowledge, skills, and abilities required by the population served.	V 293		

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V 293	Continued From page 29 CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on interview, record review, and observation, 1 of 7 audited paraprofessionals (Licensee #2/Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0205 assessment and Treatment/Habilitation or Service Plan (V112) Based on interview and record review, the facility failed to develop and implement strategies to address the needs of the clients affecting 1 of 1 audited former client (Former Client #2). CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V118) Based on interview, record review, and observation, the facility failed to ensure medications were administered as ordered by the physician affecting 1 of 1 current client (Client #1). CROSS REFERENCE: General Statute 131E-256 Health Care Personnel Registry (V132) Based on interview and record review, the facility failed to report all allegations against health care personnel, failed to complete an internal investigation and failed to protect clients during the investigation process affecting 1 of 1 audited former staff (Former Staff #5). CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) Based on interview and record review, the facility failed to report all Level III incidents to the LME	V 293		

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(local management entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident.

CROSS REFERENCE: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536)
Based on interview and record review, the facility failed to ensure staff were trained in alternatives to restrictive interventions affecting 1 of 10 audited staff members (Licensee #2/Executive Director).

CROSS REFERENCE: 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537)
Based on interview and record review, the facility failed to ensure staff were trained in seclusion, physical restraint, and isolation time-out affecting 1 of 10 audited staff members (Licensee #2/Executive Director).

CROSS REFERENCE: 10A NCAC 27G .0303 Location and Exterior Requirements (V736)
Based on interview and observation, the facility was not maintained in a clean, orderly, safe, and attractive manner.

CROSS REFERENCE: 10A NCAC 27G .0303 Location and Exterior Requirements (V738)
Based on interview and observation, the facility was not kept free from insects.

This deficiency constitutes a recited deficiency, previously cited 9/29/20 and 11/13/20.

Review on 4/8/21 of the first Plan of Protection written by Licensee #1/Director/Qualified Professional #1 dated 4/8/21 revealed:

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V 293	Continued From page 31 "What immediate action will the facility take to ensure the safety of the consumers in your care? Brighter Dayz (Licensee/Facility) will: V109: Brighter Dayz will comply with all requirements of 10A NCAC 27G .0203 including ensuring the competency of the Qualified Professional. Specifically, the Qualified Professional will receive training by a qualified trainer within the 23 days about: 1. technical knowledge; 2. cultural awareness; 3. analytical skills; 4. decision-making; 5. interpersonal skills; 6. communication skills; and 7. clinical skills. V110: Brighter Dayz will comply with all requirements of 10A NCAC 27G .0204 including ensuring the competency of the Para Professionals. Specifically, the ED (Executive Director) will receive training by a qualified trainer within the 30 days of hire or return to work: 8. technical knowledge; 9. cultural awareness; 10. analytical skills; 11. decision-making; 12. interpersonal skills; 13. communication skills; and 14. clinical skills. Specifically, QP (Qualified Professional) will ensure that all prior histories (AWOL (absent without leave)/ELOPEMENT) are inserted in the support/intervention section of the PCP (person centered plan). QP will document prior histories and have a meeting which will serve to establish which histories are still a concern, and develop strategies based on those concerns. ED will also attend retraining in core areas identified. V112: Brighter Dayz will comply with all requirements of 10A NCAC 27G .0205 including:	V 293		

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V 293	Continued From page 32 a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented b. Specifically, Clients will not be able to obtain employment unless staff is present for the entire workshift. c. Specifically, QP will ensure that interventions for historical behavior (AWOL/ELOPEMENT) are inserted in the support/intervention section of the PCP. QP will document prior histories and have a meeting which will serve to establish which histories are still a concern, and develop strategies based on those concerns. ED will also attend retraining in core areas identified. V118: Brighter Dayz will comply with all requirements of 10A NCAC 271g .0209 including ensuring all direct care staff have documented training by qualified trainer in the following topics: a. Medication dispensing: Medication packaging and labeling b. Medication administration c. Medication disposal d. Medication Storage e. Medication review f. Medication education g. Medication errors Specifically, the staff who was completing MAR (medication administration record) is no longer doing so. This responsibility has been and will be shifted back to the Executive Director. V367: : Brighter Dayz will comply with all requirements of 10A NCAC 27g .0603/.0604 including: d. Ensuring that all Level II and III incidents are reported to DHSR (Division of Health Service Regulation) and the LME/MCO (local management entity/managed care organization) as required by the prevailing NC DHHS (North	V 293		

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V 293	Continued From page 33 Carolina Department of Health and Human Services) Incident Reporting System (IRIS) within the IRIS and 10A NCAC 27g .0604 stipulated timeframes. e. The agency will keep all incident reports on file for inspection for governmental authorities. f. New hires and returning staff will be retrained in incident reporting prior to hire/return and annually thereafter. g. 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. Specifically, the provider will ensure that in addition to reporting allegations to the HCPR (Health Care Personnel Registry) (24 Hour report and 5-day working report, Incidents involving allegations against staff will be reported in IRIS. V536: Brighter Dayz will comply with all requirements of 10A NCAC 27E .0107 including: a. The agency will choose one Training On Alternatives To Restrictive Interventions curricula that all staff must complete by a qualified trainer as defined in NCAC 27E .0108 . The curriculum will a curriculum approved by the NC DMH/IDD/SAS (mental health/intellectual developmental disability/substance abuse services) on their list of approved curricula. b. The agency will ensure all newly hired and returning staff have valid Training On Alternatives To Restrictive Interventions certificate on file before working and annually thereafter. c. The agency will conduct at least quarterly self-audits to ensure this standard is met. V537: Brighter Dayz will comply with all requirements of NCAC 27E .0108. ED was retrained as part of October POC (plan of correction). Certificate if training for CPI (Crisis Prevention Institute) training is in folder. Documents scanned resulted in a blank page	V 293		

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V 293	Continued From page 34 (pg.30 of emailed documents to DHSR on 3/16/21.) V736: Brighter Dayz will comply with all requirements of NCAC 27G .0303 including: a. The agency will perform monthly self-inspection checklists available for DHSR review. b. All window sills will be cleaned as part of monthly self-inspection. c. The agency will cover any obstruction/windows that are broken, until it can be fixed by a professional to ensure clients cannot be hurt/injured. V738: Brighter Dayz will comply with all requirements of NCAC 27G .0303 including: a. Cross referenced in V736 Describe your plans to make sure the above happens. Brighter Dayz will: a. Contract with a Certified Forensic Health Care Auditor for three months to: 1. Conduct quarterly self-audits of the agency to sure compliance with this POP and any subsequent POC. The self-audits will be in the record. 2. Obtain distinct clarification from DHSR/other providers/Forensic Auditor regarding treatment strategies of prior behaviors/employment. 3. Consult with IRIS coordinator for IRIS training. 4. Shift MAR responsibility to Executive Director. 5. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live online. 6. Conduct competency-based training with the Qualified Professional and Executive Director. The initial training will be live or live online.	V 293		

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V 293	Continued From page 35 b The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented." Review on 4/13/21 of the second Plan of Protection written by Licensee #1/Director/Qualified Professional #1 dated 4/13/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? V109: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision. " Client who was working has been discharged as of December 2019. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Brighter Dayz will comply with all requirements of 10A NCAC 27G .0203 including ensuring the competency of the Qualified Professional. Specifically, the Qualified Professional will receive training by a qualified trainer by April 30, 2021 about: 1. technical knowledge; 2. cultural awareness; 3. analytical skills; 4. decision-making; 5. interpersonal skills; 6. communication skills; and 7. clinical skills. Specifically, QP will attend training on PCP's by April,18,2021 highlighting the HOW/SUPPORT section. V110: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision.	V 293		

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V 293	Continued From page 36 " Client who was working has been discharged as of December 2019. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Specifically, ED will attend training on the above by a qualified trainer by 4/30/21 in the areas below: 8. technical knowledge; 9. cultural awareness; 10. analytical skills; 11. decision-making; 12. interpersonal skills; 13. communication skills; and 14. clinical skills. V112: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The client who was employed has been discharged since December 2019. " Client that is currently in our care cannot and will not work without adequate supervision. Brighter Dayz will comply with all requirements of 10A NCAC 27G .0205 including: a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. b. Specifically, Clients will not be able to obtain employment unless staff is present for the entire work shift. c. Specifically, QP will ensure that general supervision is provided to all clients to prevent (AWOL/ELOPEMENT). Any client who had a history of AWOL within the past 12 months will have a specific supervision plan under the How/Intervention section of the goal. QP will document prior histories and have a meeting which will serve to establish which histories/behaviors are still a concern, and	V 293		

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V 293	Continued From page 37 develop strategies based on those concerns. V118: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " As of 3/01/21 the staff who was setting up the Medication Administration Record (MAR) is no longer doing so. This responsibility has been shifted to the Executive Director. Brighter Dayz will comply with all requirements of 10A NCAC 271g .0209 including ensuring all direct care staff have documented training by qualified trainer in the following topics: A Medication dispensing: Medication packaging and labeling b. Medication administration c. Medication disposal d. Medication Storage e. Medication review f. Medication education g. Medication errors The MAR will be audited weekly by the Executive Director for conformance with standards. V132: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The staff who the allegations was against is no longer employed at Brighter Dayz. Brighter Dayz will comply with all requirements of General Statute 131E-256 Health Care Personnel Registry. Specifically, Brighter Dayz will ensure that allegations against staff are reported to the HCPR within 24 hours of the provider learning of the incident. The provider will then submit the 5 day working report after completing their internal investigation. The provider will also submit an Incident Report in IRIS as part of this process within 72 hours of learning of the incident. V367: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:	V 293		

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V 293	Continued From page 38 " The QP will ensure that in addition to reporting allegations to the HCPR involving staff , Incidents involving allegations against staff will also be reported in IRIS within 72 hours. Brighter Dayz will comply with all requirements of 10A NCAC 27g .0603/.0604 including: d. Ensuring that all Level II and III incidents are reported to DHSR and the LME/MCO as required by the prevailing NC DHHS Incident Reporting System (IRIS) within the IRIS and 10A NCAC 27g .0604 stipulated timeframes. e. The agency will keep all incident reports on file for inspection for governmental authorities. f. 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. V536: Brighter Dayz will comply with all requirements of 10A NCAC 27E .0107 To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work. The ED will monitor CPI certification monthly. V537: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Brighter Dayz will ensure that all staff have	V 293		

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V 293	Continued From page 39	V 293		

current CPI training at all times. Staff without current CPI training will not be allowed to work. The ED will monitor CPI certification monthly.
V736:
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
" The broken window has been replaced on 2/18/21. A photo of the repair was submitted to DHSR on 2/18/21.
Brighter Dayz will comply with all requirements of NCAC 27G .0303 including:
a. The agency will perform monthly self-inspection checklists available for DHSR review.
b. All window sills will be cleaned as part of monthly self-inspection and inspection checklist has been updated with this new addition.
c. The agency will cover any obstruction/windows that are broken, until it can be fixed by a professional to ensure clients cannot be hurt/injured.
V738:
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
" The window in question was fixed/repaired. A photo of the repair was submitted to DHSR on 2/18/21. Window sills have been cleaned, and a photo was sent to DHSR on 4/1/2021.
Brighter Dayz will comply with all requirements of NCAC 27G .0303 including:
a. Cross reference to V736
V293:
To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions:
Cross reference response to V109,110,112,118, 132, 367, 536, 537, 736, 738

Describe your plans to make sure the above happens.
Brighter Dayz will:

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V 293	Continued From page 40 a. Contract with a Certified Forensic Health Care Auditor for three months to: 1. Conduct quarterly self-audits of the agency to sure compliance with this POP and any subsequent POC. The self-audits will be in the record. 2. Obtain distinct clarification from DHSR/other providers/Forensic Auditor regarding treatment strategies of prior behaviors/employment. 3. Consult with IRIS coordinator for IRIS training, and specifically regarding Incident report after submitting HCPR. 4. Shift MAR responsibility to Executive Director. 5. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live or online. 6. Conduct competency-based training with the Qualified Professional and Executive Director. The initial training will be live or live online. Any documents submitted to auditor will be signed off by auditor. b. The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented. c. Agency will request informal conference to discuss implementations made by provider." Review on 4/15/21 of the third and final Plan of Protection written by Licensee #1/Director/Qualified Professional #1 dated 4/15/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? V109: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and	V 293		

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V 293	Continued From page 41 will not work without adequate supervision. " Client who was working has been discharged as of December 2020. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Brighter Dayz will comply with all requirements of 10A NCAC 27G .0203 including ensuring the competency of the Qualified Professional. Specifically, the Qualified Professional will receive training by a qualified trainer by April 30, 2021 about: 1. technical knowledge; 2. cultural awareness; 3. analytical skills; 4. decision-making; 5. interpersonal skills; 6. communication skills; and 7. clinical skills. Specifically, QP will attend training on PCP's by April,18,2021 highlighting the HOW/SUPPORT section. V110: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " Client that is currently in our care cannot and will not work without adequate supervision. " Client who was working has been discharged as of December 2020. QP will also ensure that as part of HCPR notification of allegations concerning staff, an Incident report is filed in IRIS. Specifically, ED will attend training on the above by a qualified trainer by 4/30/21 in the areas below: 8. technical knowledge; 9. cultural awareness; 10. analytical skills; 11. decision-making; 12. interpersonal skills; 13. communication skills; and 14. clinical skills.	V 293		

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V 293	Continued From page 42 V112: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The client who was employed has been discharged since December 2020. " Client that is currently in our care cannot and will not work without adequate supervision. Brighter Dayz will comply with all requirements of 10A NCAC 27G .0205 including: a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. b. Specifically, Clients will not be able to obtain employment unless staff is present for the entire work shift. c. Specifically, QP will ensure that general supervision is provided to all clients to prevent (AWOL/ELOPEMENT). Any client who had a history of AWOL within the past 12 months will have a specific supervision plan under the How/Intervention section of the goal. QP will document prior histories and have a meeting which will serve to establish which histories/behaviors are still a concern, and develop strategies based on those concerns. V118: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " As of 3/01/21 the staff who was setting up the Medication Administration Record (MAR) is no longer doing so. This responsibility has been shifted to the Executive Director. Brighter Dayz will comply with all requirements of 10A NCAC 271g .0209 including ensuring all direct care staff have documented training by qualified trainer in the following topics: a. Medication dispensing: Medication packaging and labeling	V 293		

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V 293	Continued From page 43 b. Medication administration c. Medication disposal d. Medication Storage e. Medication review f. Medication education g. Medication errors The MAR will be audited weekly by the Executive Director for conformance with standards. V132: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The staff who the allegations was against is no longer employed at Brighter Dayz. Brighter Dayz will comply with all requirements of General Statute 131E-256 Health Care Personnel Registry. Specifically, Brighter Dayz will ensure that allegations against staff are reported to the HCPR within 24 hours of the provider learning of the incident. The provider will then submit the 5 day working report after completing their internal investigation. The provider will also submit an Incident Report in IRIS as part of this process within 72 hours of learning of the incident. V367: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The QP will ensure that in addition to reporting allegations to the HCPR involving staff , Incidents involving allegations against staff will also be reported in IRIS within 72 hours. Brighter Dayz will comply with all requirements of 10A NCAC 27g .0603/.0604 including: d. Ensuring that all Level II and III incidents are reported to DHSR and the LME/MCO as required by the prevailing NC DHHS Incident Reporting System (IRIS) within the IRIS and 10A NCAC 27g .0604 stipulated timeframes. e. The agency will keep all incident reports on file for inspection for governmental authorities.	V 293		

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V 293	Continued From page 44 f. 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. V536: Brighter Dayz will comply with all requirements of 10A NCAC 27E .0107 To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work. The ED will monitor CPI certification monthly. V537: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " ED was retrained as part of October POC submitted to DHSR. Certificate of CPI training is in folder. Documents scanned resulted in a blank page (pg.30 of emailed documents to DHSR on 3/16/21.) Brighter Dayz will ensure that all staff have current CPI training at all times. Staff without current CPI training will not be allowed to work. The ED will monitor CPI certification monthly. V736: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The broken window has been replaced on 2/18/21. A photo of the repair was submitted to DHSR on 2/18/21. Brighter Dayz will comply with all requirements of NCAC 27G .0303 including: a. The agency will perform monthly self-inspection checklists available for DHSR review.	V 293		

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V 293	Continued From page 45 b. All window sills will be cleaned as part of monthly self-inspection and inspection checklist has been updated with this new addition. c. The agency will cover any obstruction/windows that are broken, until it can be fixed by a professional to ensure clients cannot be hurt/injured. V738: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: " The window in question was fixed/repaired. A photo of the repair was submitted to DHSR on 2/18/21. Window sills have been cleaned, and a photo was sent to DHSR on 4/1/2021. Brighter Dayz will comply with all requirements of NCAC 27G .0303 including: a. Cross reference to V736 V293: To ensure the health, safety and welfare of clients Brighter Dayz will take the following actions: Cross reference response to V109,110,112,118, 132, 367, 536, 537, 736, 738 Describe your plans to make sure the above happens. Brighter Dayz will: a. Contract with a Certified Forensic Health Care Auditor for three months to: 1. Conduct quarterly self-audits of the agency to sure compliance with this POP and any subsequent POC. The self-audits will be in the record. 2. Obtain distinct clarification from DHSR/other providers/Forensic Auditor regarding treatment strategies of prior behaviors/employment. 3. Consult with IRIS coordinator for IRIS training, and specifically regarding Incident report after submitting HCPR. 4. Shift MAR responsibility to Executive Director.	V 293		

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V 293	Continued From page 46 5. Conduct training with newly hired and returning staff about this POP and any subsequent POC. The initial training will be live or live or online. 6. Conduct competency-based training with the Qualified Professional and Executive Director. The initial training will be live or live online. Any documents submitted to auditor will be signed off by auditor. b. The agency will not place residents in the facility until such time as all the actions in the POP are fully implemented. c. Agency will request informal conference to discuss implementations made by provider." Client #1 was 16 years old and diagnosed with Intermittent Explosive Disorder, Intellectual Developmental Disability - Mild, Autism, and Language Disorder. She had a history of self-injurious behaviors, property destruction, and physical aggression requiring assistance of local law enforcement. Former Client #2 was 17 years old and was diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, and Cannabis Use - Mild. She had a history of repeated AWOL (absent without leave), impaired judgement, risky community behaviors, substance abuse, and sex trafficking. She was job placed at a local fast food restaurant within weeks of being admitted to the facility with no assessment to determine the ability to work unsupervised. No treatment plan strategies were developed to address Former Client #2's AWOL behaviors. Furthermore, no treatment plan strategies were developed to ensure Former Client #2's safety and supervision needs were met when she worked at the local fast food restaurant. Former Client #2 left her place of employment with an	V 293		

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unidentified male after being dropped at the location by facility staff. It could not be determined where Former Client #2 went or what activities she engaged in while with this unidentified male.

Client #1 was prescribed medications to address her health needs (Desmopressin for urinary incontinence, Melatonin for sleep aid, Aripiprazole an antipsychotic used for irritability associated with autism, and Stool Softener). Due to lack of documentation on Client #1's medication administration records from December, 2020 through February, 2021, it was impossible to determine if Client #1 received her medications as ordered by the physician. Furthermore, all staff responsible for administration of Client #1's medications for the three month period did not report the medications missing from the medication administration records.

The facility did not complete an internal investigation and complete the necessary notifications after an allegation of Former Staff #5 offering marijuana to Former Client #2. There was no evidence of Licensee #2/Executive Director having current training in alternatives to restrictive intervention and seclusion, physical restraint, and isolation time-out. The facility did not repair a broken window and did not remove multiple dead insect carcasses.

Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director did not provide the clinical and administrative oversight required to meet the needs of Client #1 and Client #2 resulting in continued neglect.

This deficiency constitutes a Continued Failure to Correct the Type A1 rule violation originally cited

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V 293	Continued From page 48 for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	V 293		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that	V 367		

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

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V 367	Continued From page 50 incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level III incidents to the LME (local management entity) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 2/15/21 of the facility's Incident Reports revealed: -No incident report completed regarding an allegation of Former Staff #5 offering marijuana to Former Client #2. Interview on 3/8/21 with the Social Worker from the local Department of Social Services (DSS) revealed: -There was an investigation regarding Former Staff #5 offering marijuana to Former Client #2; -The Social Worker's supervisor investigated the matter but did not have access to Former Client #2 because Former Client #2 was AWOL (absent without leave). Interview on 4/5/21 with the local DSS Supervisor	V 367		

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revealed:
-Went to the facility on 1/7/21 at 1:30pm to meet with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director to investigate the allegation of Former Staff #5 offering marijuana to Former Client #2;
-Spoke with Client #1 on 1/7/21 while at the facility but did not get any significant information as Client #1 was "very limited with verbal skills."

Attempted interviews with Former Client #2 were unsuccessful as Former Client #2 was still missing after going AWOL from the facility on 12/20/20. Messages were left with Former Client #2's DSS Social Worker and Former Client #2's mother on 2/15/21 and 3/3/21 requesting a call if Former Client #2 was located. No call was ever received.

Interviews on 3/8/21 and 3/17/21 with Former Staff #5 revealed:
-Denied ever smoking marijuana or offering marijuana to clients;
-Already spoke with DSS regarding the allegation;
-Told DSS the same information;
-Never worked at the facility and only worked at the sister facility;
-Not sure how this allegation ever came about.

Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed:
-Responsible for entering Level II and Level III incident reports into NC IRIS working alongside the Licensed Professional and the direct care staff to ensure the information is entered;
-Denied DSS came to the facility regarding an allegation;
-DSS only went to a sister facility where an allegation was made regarding a different staff member offering marijuana to a different client.

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V 367	Continued From page 52 Interview on 3/31/21 with Licensee #2/Executive Director revealed: -The direct care staff and Licensee #1/Director/Qualified Professional #1 was responsible for entering Level II and Level III incident reports into NC IRIS and then the reports were reviewed by the Licensed Professional; -Denied there was an allegation of a staff member offering marijuana to Former Client #2; -The allegation of a different staff member offering marijuana to a different client happened at a sister facility. Interview on 4/8/21 with Licensee #1/Executive Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director. This deficiency constitutes a recited deficiency, previously cited 9/13/19, 6/23/20, and 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives	V 536		

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V 536	Continued From page 53 to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and	V 536		

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V 536	Continued From page 54 organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.	V 536		

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V 536	Continued From page 55 (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate	V 536		

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V 536	Continued From page 56 competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were trained in alternatives to restrictive interventions affecting 1 of 10 audited staff members (Licensee #2/Executive Director). The findings are: Review on 3/17/21 of Licensee #2/Executive Director's record revealed: -Hire date 8/1/18; -Training certificate for alternatives to restrictive intervention training through Nonviolent Crisis Intervention program issued 10/23/19 with expiration date 10/23/20; -No additional information regarding training for alternatives to restrictive intervention was available for review. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Was trained in Nonviolent Crisis Intervention. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -Not sure why Licensee #2/Executive Director's most current certificate for training in Nonviolent	V 536		

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V 536	Continued From page 57 Crisis Intervention was not provided but the training was completed in October, 2020. This deficiency constitutes a recited deficiency, previously cited 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives,	V 537		

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V 537	Continued From page 58 measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the	V 537		

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V 537	Continued From page 59 outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation	V 537		

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V 537	Continued From page 60 time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility	V 537		

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V 537	Continued From page 61 failed to ensure staff were trained in seclusion, physical restraint, and isolation time-out affecting 1 of 10 audited staff members (Licensee #2/Executive Director). The findings are: Review on 3/17/21 of Licensee #2/Executive Director's record revealed: -Hire date 8/1/18; -Training certificate for seclusion, physical restraint, and isolation time-out through Nonviolent Crisis Intervention program issued 10/23/19 with expiration date 10/23/20. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Was trained in Nonviolent Crisis Intervention. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -Not sure why Licensee #2/Executive Director's most current certificate for training in Nonviolent Crisis Intervention was not provided but the training was completed in October, 2020. This deficiency constitutes a recited deficiency, previously cited 9/29/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly	V 736		

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V 736	Continued From page 62 manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on interview and observation, the facility was not maintained in a clean, orderly, safe, and attractive manner. The findings are: Observation on 2/15/21 at approximately 11:30am of the facility revealed: -Broken window in bedroom #1 (Former Client #2's bedroom). The broken windowpane was on 6 pane-window, three over three, and the one pane which was broken was the middle pane on the bottom half of the window. The hole in the windowpane was approximately a four inch diameter hole with jagged edges of plexiglass. The 6 pane window was on the interior of the room and was backed by a solid glass storm window which was intact; -Broken blind in bedroom #2 (Client #1's bedroom); -Broken curtain rod bedroom #3 (single room facing the front of the facility). Interview on 2/17/21 with Licensee #1/Director/Qualified Professional #1 revealed: -Was aware of the broken window in Former Client #2's bedroom; -Had previously contacted a repairman to fix the broken window; -Did not follow up to ensure the broken window was repaired but will do so today. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed:	V 736		

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V 736	Continued From page 63 -Not sure how the window in Former Client #2's bedroom broke; -Sent a picture of the repaired window to DHSR surveyors on 2/18/21 after the broken window was brought to his attention again and will resend the picture of the repaired window again now; -Will make sure there are no more broken windows moving forward; -Had originally reported the broken window to the repair shop around January, 2021 and did not follow up regarding the broken window; -The repair shop was to come to the facility to repair the window and they did not come; -Did not follow up regarding the broken window until DHSR surveyors were present and then followed up and the window was repaired the next day (2/18/21). Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Responsible for house inspections monthly and "walks around the house and looks around;" -The House Manager completed the house inspections and Licensee #2/Executive Director checked behind the House Manager; -When asked to clarify who completed house inspections, the question was not answered; -The window in Former Client #2's bedroom was broken prior to Former Client #2's admission (10/15/20); -There were little pebbles around the facility; -Could hear a ding; -The landscaper broke the window; -Repair of the window in Former Client #2's bedroom was delayed because it "slipped through the cracks" and the repairman did not come out . Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey	V 736		

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V 736	Continued From page 64 exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director. This deficiency constitutes a recited deficiency, previously cited 11/13/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on interview and observation, the facility was not kept free from insects. The findings are: Observation on 2/15/21 at approximately 11:30am of the front of the facility revealed: -Numerous insect carcasses in the windowsills of the two front windows furthest from the front door overlooking the front porch; -The insect carcasses appeared similar to a beetle. Interview on 3/31/21 with Licensee #1/Director/Qualified Professional #1 revealed:	V 738		

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V 738	Continued From page 65 -Dead bugs are on the outside of the windows; -A local pest control company came to the facility and treated a hornet's nest in the window; -The landscapers are responsible to dust off the windows; -The staff clean the inside of the facility. Interview on 3/31/21 with Licensee #2/Executive Director revealed: -Responsible for house inspections monthly and "walks around the house and looks around;" -The House Manager completed the house inspections and Licensee #2/Executive Director checked behind the House Manager; -When asked to clarify who completed house inspections, the question was not answered; -"Maybe we can spray with lye;" -Will make sure the multiple dead bug carcasses are cleaned; -The landscapers clean the outside of the facility and the staff clean the inside of the facility. Interviews on 4/8/21 with Licensee #1/Director/Qualified Professional #1 and Licensee #2/Executive Director during the survey exit meeting revealed: -When asked if there was additional information to present or comments to make, no additional information was provided by either Licensee #1/Director/Qualified Professional #1 or Licensee #2/Executive Director. This deficiency constitutes a recited deficiency, previously cited 11/13/20. This deficiency is cross-referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1.	V 738		