	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
,	5. G5.W.E6.W6.W	1521111110711101152111	A. BUILDING: _			
		MHL036-331	B. WING		04/16	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
V 109	on 4/16/21 as a resulticensees informal con 12/2/20. The complation (Intake #NC173223). The facility is licensed category: 10A NCACT Treatment Staff Secundolescents.	nference meeting held on int was unsubstantiated Deficiencies were cited. If for the following service 27G .1700 Residential	V 109			
	10A NCAC 27G .0203 QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be not qualified professional (b) Qualified professional (b) Qualified professionals shall deand abilities required (c) At such time as a employment system in the qualified professionals shall deand abilities required (d) Competence shall deand abilities professionals shall deand Competence shall deand competence shall deand competence (a) cultural awarene (b) cultural awarene (c) cultural awarene (c) cultural awarene (c) interpersonal skills (d) communication second communication s	B COMPETENCIES OF SSIONALS AND SSIONALS privileging requirements for s or associate professionals. onals and associate emonstrate knowledge, skills by the population served. competency-based s established by rulemaking, ionals and associate emonstrate competence. Il be demonstrated by including: dge; ss;				

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

TITLE (X6) DATE

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			5 14/110		R
		MHL036-331	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
RDIGHTE	R DAYZ LLC	837 LYNH	AVEN DRIVE		
BRIGHTE	R DATZ LLC	GASTON	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
V 109	develop and impleme for the initiation of an plan upon hiring each (g) The associate pro	dy for each facility shall nt policies and procedures individualized supervision associate professional. ofessional shall be fied professional with the the period of time as	V 109		
	(Licensee #1/Director failed to demonstrate				
	revealed: -Hire date of 2/1/18; -Was retrained in Firs Resuscitation, Bloodh Medication Administra Mental Health/Develo Disabilities/Substance Specific Trainings, All Intervention, Seclusio Isolation Time-Out, O Confidentiality, Popula Documentation, Crisis Management, Person	t Aid, Cardiopulmonary porne Pathogens, ation, Seizure Management, pmental e Abuse Services, Client ternatives to Restrictive in, Physical Restraint, and rientation, Rights and ation Served, s Planning and Centered Planning, Health Competency, Sexually			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILDING		R
		MHL036-331	B. WING		04/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
RDIGHTE	R DAYZ LLC	837 LYNH	AVEN DRIVE		
DICIONIL	N DATE LLO	GASTONI	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 109	/ 109 Continued From page 2		V 109		
	Improvement System	during October, 2020.			
	Review on 4/1/21 of L #1/Director/Qualified Description revealed: -Job description signe #1/Director/Qualified 2/1/18 revealed job r supervision of the a para-professionals, o provision of direct psy children or adolescen planning meetings, co	Licensee Professional #1's Job ed by Licensee Professional #1 dated esponsibilities included " associate professionals and versight of emergencies, ycho educational services to tts, participation in treatment pordination of each child or nt plan, provision of basic			
	Division of Health Set survey revealed: -Licensee #1/Director was cited for failure to knowledge, skills, and population served; -Plan of Protection dasigned by Licensee # Professional #1 revearequirements of 10A ensuring the competer Professional. Specific Professional will rece trainer by 10/18/20: to awareness; analytica	ed as a result of 9/29/20 rvice Regulation (DHSR) f/Qualified Professional #1 of demonstrate the distriction abilities required by the lated 9/29/20 written and 1/Director/Qualified lated: "will comply with all NCAC 27G .0203 including ency of the Qualified			
	completed in respons	the Plan of Correction te to the 9/29/20 DHSR correction completion date of			

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE S	
			_		F	
		MHL036-331	B. WING		1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTEI	R DAYZ LLC		VEN DRIVE			
	OLUMBA DV OT		, NC 28052	DDOWDEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	Continued From page	3	V 109			
	of 10A NCAC 27G .02 competency of the Qualitraining by a qualified knowledge, 2. cultura skills, 4. decision-maked. Communication skill addition the Qualified by a qualified by a qualified by a qualified instruct 2. client rights and comanagement and planning conducting a ensure compliance wiperson-centered platicensed Mental Heal and approve allpersimplementation. The	fied Professional will receive trainer in: 1. technical I awareness, 3. analytical king, 5. interpersonal skills, Is, and 7. clinical skills. In Professional will be trained or in 1. cultural competency, infidentiality, 3. crisis inning, 4. person-centered admission assessments. To lith standards around				
	-December 2020, Jan 2021 MARs (medicati were not kept current determine if medicatio ordered (Refer to 10A	Client #1 record revealed: nuary2021 and February con administration records) making it impossible to ons were administered as a NCAC 27G .0209 ents (V118) for specifics.				
	revealed: -Former Client #2's trevealed no strategies leave) or methods of	Former Client #2's record eatment plan dated 5/1/20 s for AWOL (absent without ensuring supervision when despite the client's history				
		2/15/21 of the facility's s revealed there were no s.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	
		MHL036-331	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PDICUTE	R DAYZ LLC	837 LYNH	AVEN DRIVE			
BRIGHTE	R DATZ LLC	GASTONIA	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 109	Continued From page	e 4	V 109			
V 166	Review on 2/15/21 of Reports revealed: -There was no Level regarding the allegation offering marijuana to Interview on 2/17/21 of #1/Director/Qualified -Was responsible for plan goals and strated -Not sure why there a Client #1's medication -Would need to ask thregarding the lack of administration for Clied-The House Manager overseeing the MARs -It was not his respondances.	the facility's Incident III incident report completed on of Former Staff #5 Former Client #2. with Licensee Professional #1 revealed: developing the treatment gies. are missing medications on as administration records; and House Manager motation of medication ent #1; was responsible for s; sibility to ensure dead bug				
	-Was responsible for goals and strategies; -Dead bugs on the wiresponsibility of the lacontrol company camhornet's nest; -Not sure how the wirbedroom broke; -Had originally reporter repair shop around Jafollow up regarding the -Did not follow up reguntil DHSR surveyors followed up and the widay (2/18/21).	Professional #1 revealed: developing treatment plan Indowsills are the andscapers after the pest e to the facility to treat a Indow in Former Client #2's Indeed the broken window to the anuary, 2021 and did not				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or doring of the state of the s	IDENTIFICATION NOWIBER.	A. BUILDING: _		
		MHL036-331	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 109	brought forward by D #5 offering marijuana -The reason behind n Client #1's medication "human error" Interviews on 4/8/21 of #1/Director/Qualified survey exit meeting re -Not sure why Licens most current certifical Crisis Intervention was training was complete Observation on 2/15/2 11:30am of the facility -Broken window in be #2's bedroom). The begrane which was brok the bottom half of the windowpane was app diameter hole with jag The 6 pane window we room and was backed window which was info Observation on 2/15/2 11:30am of the front of -Numerous insect car the two front windows overlooking the front -The insect carcasses beetle.	e facility; mplete an internal cation to Health Care egarding the allegations SS regarding Former Staff a to Former Client #1; nissing medications on administration records was with Licensee Professional #1 during the evealed: ee #2/Executive Director's te for training in Nonviolent as not provided but the ed in October, 2020. 21 at approximately v revealed: edroom #1 (Former Client broken windowpane was on e over three, and the one en was the middle pane on window. The hole in the broximately a four inch gged edges of plexiglass. vas on the interior of the d by a solid glass storm tact. 21 at approximately of the facility revealed: crasses in the windowsills of a furthest from the front door	V 109		

Division of Health Service Regulation

STATE FORM 6899 LVKS11 If continuation sheet 6 of 66

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	TIPLE CONSTRUCTION (X3) DATE SI COMPLE		
						R
		MHL036-331	B. WING		04	/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From page	e 6	V 109			
	previously cited 9/29/	20.				
		ss-referenced into 10A ope (V293) for a Continued oe A1.				
V 110	27G .0204 Training/S Paraprofessionals	upervision	V 110			
	SUPERVISION OF P. (a) There shall be not paraprofessionals. (b) Paraprofessionals associate professional professional as specifications of Subchapter. (c) Paraprofessionals knowledge, skills and population served. (d) At such time as a employment system in then qualified professionals shall defend the competence shall exhibiting core skills in technical knowled (2) cultural awarene (3) analytical skills; (4) decision-making; (5) interpersonal skills. (6) communication served.	fied in Rule .0104 of this s shall demonstrate abilities required by the competency-based s established by rulemaking, cionals and associate emonstrate competence. Il be demonstrated by including: dge; ss; lls; skills; and dy for each facility shall ent policies and procedures individualized supervision				

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STATE FORM 6899 LVKS11 If continuation sheet 7 of 66

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Division of Health Service Regulation

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R
		MHL036-331	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTFI	R DAYZ LLC	837 LYNH/	AVEN DRIVE		
		GASTONIA	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 110	Continued From page	e 7	V 110		
	(Licensee #2/Executive	ecord review, and idited paraprofessionals			
		ation served. The findings			
	Director's record rever- Hire date of 2/1/18Was retrained in First Resuscitation, Bloodh Medication Administra Mental Health/Develor Disabilities/Substance Specific Trainings, Ri Population Served, C Management, Health Correction, Documen Planning, Cultural Co Accessibility of Recor Youth, and Incident R System during Octob	at Aid, Cardiopulmonary porne Pathogens, ation, Seizure Management, opmental e Abuse Services, Client ghts and Confidentiality, risis Planning and and Safety, Plan of tation, Person Centered mpetency, Security and rds, Sexually Aggressive desponse Improvement er, 2020.			
	Director's Job Description signed #2/Executive Director responsibilities including resources) records, comprocess, MARs (med records) planning out authorizations, commended to the comprocess of the comprocess o	ed by the Licensee dated 2/3/18 revealed job ed "HR (human lient records, intake ication administration ing, filing reports,			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
7.1.12 . 27.1.1		.52	A. BUILDING:		55	
		MHL036-331	B. WING		04	R I/ 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
		837 LYNI	HAVEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTON	IIA, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 110	Continued From page	e 8	V 110			
	management entities), DSS (Department of				
		SR (Division of Health				
	Service Regulation),	•				
		nile Justice), etc. schedule				
	, · ·	ancial management, develop				
		rformance, handle conflict				
	with staff and client, a	assist with discharge				
	process, Etc.: perfori	ming different task that can				
	vary by setting"					
	Review on 3/18/21 of	the Statement of				
		ed as a result of 9/29/20				
	Division of Health Se	rvice Regulation (DHSR)				
	survey revealed:					
		ve Director was cited for				
		e the knowledge, skills, and				
	abilities required by the					
	-Plan of Protection w	9				
		Qualified Professional #1 nply with all requirements of				
		4 including ensuring the				
	competency of the pa					
		ed and returning para				
		eive training by a qualified				
	trainer prior to starting					
		wareness, analytical skills,				
	decision-making, inte	•				
	communication skills,	and clinical skills"				
		Client #1's record revealed:				
		nuary 2021 and February				
	,	ion administration records)				
		making it impossible to				
		ons were administered as				
	ordered (Refer to 10					
	iviedication Requirem	ents (V118) for specifics.				
	Review on 2/15/21 of revealed:	Former Client #2's record				
		eatment plan dated 5/1/20				

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	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMF	SURVEY
		MHL036-331	B. WING			R / 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	-	
TO UNIC OF T	NOVIDEN ON OUT FIELD		HAVEN DRIVE	, 211 0002		
BRIGHTE	R DAYZ LLC		NIA, NC 28052			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 110	Continued From page	9	V 110			
	leave) or methods of	s for AWOL (absent without ensuring supervision when despite the client's history				
		2/15/21 of the facility's serevealed there were no				
		III incident report completed on of Former Staff #5				
	Director revealed: -Responsible for hous "walks around the hou- Responsible for " manager;" -The House Manager inspections and Licer checked behind the HWhen asked to clarif inspections, the ques -"Maybe we can sprate the multiple insect car -Denied Department of an investigation at the -Denied having to cor investigation or notific Personnel Registry re brought forward by Di #5 offering marijuana -When asked why Cli not listed on the MAR know why it wasn't or	y who completed house tion was not answered; y with lye (when discussing rcasses in the windowsills);" of Social Services initiated e facility; mplete an internal				

Division of Health Service Regulation

STATE FORM 6899 LVKS11 If continuation sheet 10 of 66

	or riealth Service Regu				Taxas = 1== = 1.1=1.
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
					R
		MHL036-331	B. WING		04/16/2021
		200 001	I.		1 04/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
DDICUTE	D DAVZ 1 1 0	837 LYNHA	VEN DRIVE		
BRIGHTE	R DAYZ LLC	GASTONIA	, NC 28052		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
V 110	Continued From page	: 10	V 110		
	-Repair of the window	in Former Client #2's			
	bedroom was delayed	d because it "slipped through			
	_	epairman did not come out .			
	Interviews on 4/8/21 v	vith Licensee #2/Executive			
	Director during the su	rvey exit meeting revealed:			
	-Not sure why License	ee #2/Executive Director's			
	most current certificat	e for training in Nonviolent			
	Crisis Intervention wa	s not provided but the			
	training was complete	ed in October, 2020.			
	Observation on 2/15/2	21 at approximately			
	11:30am of the facility	revealed:			
	-Broken window in be	droom #1 (Former Client			
	#2's bedroom). The b	oroken windowpane was on			
	6 pane-window, three	over three, and the one			
	pane which was broke	en was the middle pane on			
	the bottom half of the	window. The hole in the			
	windowpane was app	roximately a four inch			
		ged edges of plexiglass.			
	•	as on the interior of the			
	room and was backed	d by a solid glass storm			
	window which was int	act.			
	Observation on 2/15/2	• • •			
		of the facility revealed:			
		casses in the windowsills of			
		furthest from the front door			
	overlooking the front				
		s appeared similar to a			
	beetle.				
	This deficiency consti	tutes a recited deficiency,			
	previously cited 9/29/2	_			
	, ,				
	This deficiency is cros	ss-referenced into 10A			
		ope (V293) for a Continued			
	Failure to Correct Typ	e A1.			
	,,				

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STATE FORM 6899 LVKS11 If continuation sheet 11 of 66

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-331	B. WING		04	R I/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC		HAVEN DRIVE NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 112	Continued From page	÷ 11	V 112			
V 112	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for client receive services beyond (d) The plan shall incomplete the projected date of achieved by provision projected date of achieved by strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of the projected date of achieved by provision projected date of achieved by strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of the projected date of achievement (b) written consent of responsible party, or a responsible party.	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude: I that are anticipated to be a of the service and a devement; I view of the plan at least on with the client or legally roboth; I to no or assessment of	V 112			
	failed to develop and address the needs of	as evidenced by: nd record review, the facility implement strategies to the clients affecting 1 of 1 (Former Client #2). The				

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MHL036-331 STREET ADDRESS, CITY, STATE, ZIP CODE 87 LYNHAVEN DRIVE REQUIATORY OR LSC DENTIFYING INFORMATION) WHITE PRETTY TAG PROVIDERS PLAN OF CORRECTION FROM GRAND AND CORRECTION PRETTY TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 112 Indings 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 affer 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 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: -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: -no strategies to address employment; -ros strategies to address employment; -ro			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4)10 SUMMARY STATEMENT OF DESIGNOISS (X4)10 SUMMARY STATEMENT OF DESIGNOISS (X4)10 SUMMARY STATEMENT OF DESIGNOISS (X6)10 SUMMARY STATEMENT OF SUMMARY (X6)11 SUMMARY STATEMENT OF SUMMARY (X6)11 SUMMARY STATEMENT OF SUMMARY (X6)11 SUMMARY STAT				A. BUILDING			
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CASTONIA, NC 28052 CASTONIA NC 28052	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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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	V 112	Continued From page	: 12	V 112			
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		findings are:					
3/8/21 from Former Client #2's Department of Social Services (DSS) Legal Guardian revealed: -"Here is the information you requested regarding		revealed: -Admitted 10/15/20; -AWOL (absent withous) -Discharged 12/30/21 to facility after the 12/17 years old; -History of repeated Arisky community behaved and sex trafficking; -Job placed at a local weeks of admission to assessment to determ unsupervised; -Treatment plan dated no strategies for AWO supervision when awathe client's history and Treatment plan updar client has done well a continues to work at ["	ut leave) 12/20/20; as a result of not returning 20/20 AWOL; aWOL, impaired judgement, aviors, substance abuse, fast food restaurant within the facility with no nine the ability to work d 5/21/20 revealed: gies to address OL or methods of ensuring ay from the facility despite d job placement; te 12/3/20 revealed:"The the placement and local fast food restaurant]				
		3/8/21 from Former Client #2's Department of Social Services (DSS) Legal Guardian revealed:					
'It was reported to the group home staff by the		[Former Client #2] fro	m our 2.24.21 court report:				
employer, that the week prior to her running away, [Former Client #2] had been living work		employer, that the we away, [Former Client	ek prior to her running #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"		She was returning to home staff picking he also informed that [Fo	work prior to the group r up.The group home was ormer Client #2] had been in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		MHL036-331	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 112	Continued From page	e 13	V 112		
	unsuccessful as Forn missing after going A' 12/20/20. Messages #2's DSS Social Worl mother on 2/15/21 an	with Former Client #2 were mer Client #2 was still WOL from the facility on were left with Former Client er and Former Client #2's d 3/3/21 requesting a call if located. No call was ever			
	Legal Guardian reveal -Former Client #2 wan December, 2020 after of the property of the proper	s on AWOL status since r leaving the facility; d a significant history of d in early October, 2020 y with a peer. When orted Former Client #2 met a store and had sex with him			
	Legal Guardian's Sup -Former Client #2 we December, 2020 and -Former Client #2 wa Legal Guardian from AWOL; -Former Client #2 wa food restaurant while facility; -Former Client #2 wa	nt AWOL from the facility in had still not been located; s in touch with her DSS a blocked number while s employed at a local fast receiving treatment from the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331 B. WING		R 04/16/2021	
NAME OF PROVIDE	ER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•
BRIGHTER DAY	Z LLC		AVEN DRIVE A, NC 28052		
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staff This emp who offic Inter Dep -For in co she Atte man resta were ansv emp resta leav Inter -It w #2 o resta -Fac food #2) susp work Inter -For -For resta -Wo som	was reported by loyment to Licens then reported the e. Tylew on 3/3/21 with artment of Juvenil mer Client #2 was portact with her mowill not return until mpted interviews agement team of aurant where Forre unsuccessful. Nower questions reguloyment and phore aurant were unansing a voicemail merview on 3/8/21 with as not necessary ince she was at was not necessary ince she was not ne	a car with an unknown male. Former Client #2's place of see #2/Executive Director information to the DSS with Former Client #2's le Justice Worker revealed: so on AWOL status and was other and told her mother ill she turns 18 years old. on 3/3/21 and 3/22/21 of the the local fast food mer Client #2 was employed lobody was available to arding Former Client #2's ne calls to the local fast food swered with no option of essage. ith Staff #1 revealed: to check on Former Client ork at the local fast food popping into [local fast eck on her (Former Client orted that there was Former Client #2 leaving	V 112		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	A. BUILDING:		COMPLETED		
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		MHL036-331	B. WING		04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		837 LYNHA	VEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTONIA	, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
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V 112	Continued From page	e 15	V 112			
V 112	restaurant; -Former Client #2 had on some shifts; -There was no need to check on her while shifter was no need to check on her while shifter was not composed to the check of got off work earlier was not comforted. Left her employment she was not comforted #1/Director/Qualified Licensee #2/Executive -Former Client #2 had restaurant and used to -Former Staff #4 did in information about Former Staff #4 did information about Former Staff #4 did information about Former Staff #4 did information about Former Staff #4 started to Client #2's work scherestaurant so they conclient #2 needed to be -Facility staff did not work but dropped her front of the restaurant -Facility staff did not her staurant -Facility sta	d to be picked up from work o visit Former Client #2 or ne was at work; uld call the facility if she got arly. with Former Staff #4 with the facility because ble with the way Licensee Professional #1 and e Director ran the facility; d a job at a local fast food to leave work; not have any specific mer Client #2 leaving work to Former Staff #4's hire date to get print-outs of Former dule at the local fast food uld confirm when Former the at work; walk Former Client #2 into to off and picked her up in to to get possible work of the local fast walk former Client #2 into to off and picked her up in to the control of the local fast	V 112			
		eck on Former Client #2.				
	Interview on 3/9/21 w					
	Professional revealed					
		rked at a local fast food				
	restaurant; -Former Client #2 was	s dropped off and picked up				
	from her shift by staff					
		local fast food restaurant to				
		ent #2 during her shifts;				
		owledge of Former Client #2				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		MHL036-331	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTE	R DAYZ LLC	837 LYNH	AVEN DRIVE		
DICIONIL	N DAIZ ELO	GASTONIA	A, NC 28052		
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V 112	Continued From page	e 16	V 112		
	unidentified individua	l.			
	revealed: -Did not know anythir	with the House Manager ng about Former Client #2 ocal fast food restaurant ndividual.			
	-Former Client #2 had restaurant and the factor DHSR on 11/13/20) by treatment plan;" -Staff transported For -Former Client #2 was with staff calling and announced and unant fast food restaurant with group home; -Licensee #2/Executive Former Client #2 was	Professional revealed: d a job at a local fast food cility was "written up (by ecause it was not in her mer Client #2 to work; s monitored while at work driving by work both nounced because the local vas in close proximity to the ve Director was notified that leaving her place of			
	#1/Director/Qualified -Licensee #1/Director and Licensee #2/Exe of Former Client #2 le unidentified man 2 da (12/20/20) so they so meeting; -Former Client #2 der questioned y License Professional #1 and L Director; -Staff told Licensee # Professional #1 and L Director that Former (1)	e Director notified Licensee Professional #1; //Qualified Professional #1 cutive Director were notified eaving work with an eaving to her going AWOL heduled an emergency team nied leaving work when e #1/Director/Qualified Licensee #2/Executive			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7 501251110.		R		
MHL036-331		B. WING		04/16/2021		
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC		IAVEN DRIVE IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	: 17	V 112			
	Director revealed: -Former Client #2 had restaurant and had a address the employm-Staff checked on For three hours when she food restaurant was restaurant was restaff may have also the phone sometimes. Was informed Former Work with an unidentiff Former Client #2 went Licensee #2/Executive emergency team meed id not return to work-Could not recall who was leaving work with Interviews on 4/8/21 w#1/Director/Qualified Licensee #2/Executive exit meeting revealed -When asked if there to present or commer information was provi #1/Director/Qualified #2/Executive Director This deficiency constituted 9/29/	rmer Client #2 every two to a worked as the local fast not far from the facility; called Former Client #2 on a when she was at work; er Client #2 was leaving fied male two days before at AWOL (12/20/20) so the Director scheduled an eting and Former Client #2; reported Former Client #2 in an unidentified male. With Licensee Professional #1 and the Director during the survey: was additional information and the birector during the survey: was additional information and the birector during the survey: tutes a recited deficiency, 20. ss-referenced into 10 A ope (V293) for a Continued				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		MHL036-331	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	10A NCAC 27G .0203 REQUIREMENTS (c) Medication admini (1) Prescription or no only be administered order of a person auti drugs. (2) Medications shall clients only when auti client's physician. (3) Medications, inclu administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor	estration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following:	V 118			
	This Rule is not met Based on interview, r observation, the facili	ecord review, and				

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Division c	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL036-331	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	
	_	837 LYNI	HAVEN DRIVE		
BRIGHTER DAYZ LLC		IIA, NC 28052			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
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			+	<u> </u>	
V 118	Continued From page	• 19	V 118		
		ministered as ordered by the			
		of 1 current client (Client			
	#1). The findings are	¢			
	Poviou on 2/15/21 ar	nd 3/16/21 of Client #1's			
	record revealed:	10 3/10/21 Of Client #15			
	-Admitted 10/15/20;				
		rmittent Explosive Disorder,			
		nental Disability - Mild,			
	Autism, Language Dis	sorder;			
	-16 years old				
		ous behaviors, property			
		sical aggression requiring			
	assistance of local law -Physician's orders da	•			
	_	ry incontinence) 0.2mg 2			
		r of sleep), Melatonin (sleep			
	, , , , , , , , , , , , , , , , , , , ,	plets) hs, Aripiprazole			
	(antipsychotic used for	or irritability associated with			
	, -	laily, and Stool Softener			
	100mg 1 cap daily;				
		ted 2/21/21 to discontinue			
	Aripiprazole 10mg 1 t	tab daily; าuary 2021, and February,			
	2021 MARs revealed	•			
	-no documentation of				
		December, January, and			
	February MARs;				
		f administration of Melatonin			
		nuary, and February MARs;			
	-no documentation of February MAR;	Aripiprazole on the			
		f administration of stool			
	softener on 2/2/21.	daminoudation of otool			
	Interview on 3/3/21 w				
	Pharmacist revealed:				
		ribed Desmopressin since all re-fill dated of 1/5/21 and			

2/3/21;
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	IED	
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		MHL036-331	B. WING		04/16	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC	837 LYNHA	VEN DRIVE			
DICTOTTE	N DAIL LLO	GASTONIA	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	20	V 118			
	-Client #1 was prescriwith additional re-fill of 2/3/21; -Client #1 was prescri 11/9/20 with additional 1/5/21; -Did not know if Clien discontinued; -Provided the option the pharmacy but the facility swork with" -All medication orders to another local pharmacy.	ibed Melatonin since 11/9/20 lates of 12/7/20, 1/5/21, and libed Aripiprazole since al refill dates of 12/7/20 and the #1's Aripiprazole was no pre-print the MARs at the lility was not interested; staff) are not very easy to sewere recently transferred macy.				
	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"					
	a time; -"Look at the medic MARs to make sure it" Interview on 3/3/21 w revealed: -Left her employment	ations as needed; in with MARs missing ations to clients one client at cations and compare it to the is the correct medications				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		MHL036-331	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 118	-Administered medica-Did not remember sp. Client #1 had any me MARs; -" Check the persor check the MAR becaumedications to give, a prescriptions" Interview on 3/9/21 w Professional revealed: -Did not administer multerview on 2/15/21 v revealed: -Not all of Client #1's the MARs for December February 2021 - "it ware and the months of December February 2021 to reposit to make the MARs. [Licenseed over the MARs. Not a war was unable to identify were administered professional revealed over the MARs. Not a was unable to identify were administered professional revealed.	Professional #1 and e Director ran the facility; ations at the facility; becifics about the MARs or if dications missing from the an, check the prescriptions, use that tells what and match the labels to the with the Associate di: ledications at the facility. with the House Manager medications are listed on ober 2020, January 2021, and as a mistake;" lee House Manager during liber 2020, January 2021, or ort the errors with the MARs. with the House Manager MARs. I am no longer over a #2/Executive Director] is leven sure what I did;" fry if Client #1's medications operly. with the Licensee Professional revealed: ormation regarding the is was responsible for	V 118			
	Interview on 3/31/21	with the Licensee				

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DUILDING: _		_	
		MHL036-331	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DDIOUTE	2 PAYZ I I O	837 LYNH	AVEN DRIVE			
BRIGHTER DAYZ LLC GASTONIA		A, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 22	V 118			
	#1/Director/Qualified -The medication adm retrieve the medication cabinet, wear gloves, pre-packaged medicat plastic label, hand the clients for the clients -It was "human erro medications were not -The House Manager ensuring the medicati administered but now Director is handling o -Believed Client #1 re medications as order the medications arrive pre-packaged and the according to the phys essentially "took th (medication administr	Professional revealed: inistration protocol was to ons from a double locked get the pharmacy ation packs, peel back the e plastic receptacle to the to take the medications; or" that all of Client #1's clisted on the MARs; was responsible for ions were signed as the Licensee #2/Executive eversight of the MARs; eceived all of her ed by the physician because ed from the pharmacy e pharmacy filled the orders ician's orders which e thought out of it				
	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					
	staff to check the clie -When asked why Cli listed on the MARs sh why it wasn't on there was a new medication back on;" -Believed Client #1 re	ent #1 medications were not the revealed "l don't know the honestlymaybe there in subtracted and then added eceived all of her				
	"if you look on the	ed by the physician because back of the pill packs it has the pill pack listedthe				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
		MHL036-331	B. WING		1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTEI	R DAYZ LLC		VEN DRIVE , NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	of the blister pack" Interviews on 4/8/21 of #1/Director/Qualified Licensee #2/Executive exit meeting revealed -When asked if there to present or commer information was provi #1/Director/Qualified #2/Executive Director Observation on 2/15/2 of Client #1's medicat -Stool softener 100mg Melatonin 10mg in pholister packs dispensed but to the failure to a medication administrate determined if clients in as ordered by the phy This deficiency constitute previously cited 9/13/ This deficiency is cross	with Licensee Professional #1 and e Director during the survey : was additional information hts to make, no additional ded by either Licensee Professional #1 or Licensee during the exit meeting. 21 at approximately 8:35am ions revealed: g, Desmopressin 0.2 mg, armacy pre-packaged daily ed 2/3/21 ccurately document ation it could not be eccived their medications visician. tutes a recited deficiency,	V 118			
V 132	G.S. 131E-256(G) HC Allegations, & Protect G.S. §131E-256 HEA REGISTRY	CPR-Notification,	V 132			
		es shall ensure that the d of all allegations against l. including iniuries of				

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MHL036-331 MARE OF PROVIDER OR SUPPLIER SIMMARY CIATEMENT OF DEPOSITIONS REGISTER DAY LLC SIMMARY CIATEMENT OF DEPOSITIONS RECULATORY OR LSC IDENTIFYING INFORMATION) 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 C.S. 131E-136 or hospics services as defined by C.S. 131E-136 or hospic services as defined by C.S. 131E-136 or hospic services as defined by C.S. 131E-136 or hospic services are defined by C.S. 131E-136 or hospic service		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER BRIGHTER DAYZ LLC STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (A4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES TAG CHOIC DEFICIENCY OR LSC IDENTIFYING INFORMATION) 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-201 are being provided. b. Misappropriation of the property of a health care facility or a patient or client. c. Misappropriation of the property of a healthcare facility or a patient or client. e. Fraud against a health care facility or against a patient or client. e. Fraud against a health care facility or against a patient or client. e. Fraud against a health care facility or against a patient or client. Fraud in the 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 investigations must be reported to the Department within five working days of the initial	ANDILAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _			
SUMMARY STATEMENT OF DEFICIENCIES GASTONIA, NC 28052 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE COMPACT. V 132 INTERIOR TO THE APPROPRIATE DATE OF TO THE APPROPRIATE DATE OF TAG (EACH CORRECTIVE ACTION SHOULD BE COMPACT. TAG (EACH CORRECTIVE ACTION TAG (EAC			MHL036-331	B. WING			
(A) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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-201 are being provided. c. Misappropriation of the property of a healthcare 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 investigations must be reported to the Department within five working days of the initial	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NATION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	BRIGHTE	R DAYZ LLC	837 LYNHA	VEN DRIVE			
V 132 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-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a health care facility or 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 investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial	DICIONIC	C DATE LEG	GASTONIA	, NC 28052			
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-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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE COMPLETE	
	V 132	unknown source, whi any act listed in subd (which includes: a. Neglect or abuse facility or a person to as defined by G.S. 13 as defined by G.S. 13 b. Misappropriation in a health care facilit (b) of this section incl care services as defined by G.S. 13 b. Misappropriation in a health care facilit (b) of this section incl care services as defined by G.S. 13 b. Misappropriation of care services as defined by G.S. 13 b. Misappropriation of care services as defined by G.S. Misappropriation of care being provided. c. Misappropriation of drugs facility or to a patient e. Fraud against a hapatient or client for providing services). Facilities must have acts are investigated to protect residents from the care investigation is in provincestigations must be Department within five	ch appear to be related to ivision (a)(1) of this section. of a resident in a healthcare whom home care services 31E-136 or hospice services 31E-201 are being provided. of the property of a resident y, as defined in subsection uding places where home ned by G.S. 131E-136 or defined by G.S. 131E-201 of the property of a selfonging to a health care or client. ealth care facility or against whom the employee is evidence that all alleged and must make every effort om harm while the gress. The results of all e reported to the e working days of the initial	V 132	DETICIENCE!)		

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL036-331	B. WING		04	R I/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
PDICUTE	R DAYZ LLC	837 LYN	HAVEN DRIVE			
BRIGHTE	R DATZ LLC	GASTON	IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 132	Continued From pag	e 25	V 132			
	failed to report all alle personnel, failed to convestigation and fail the investigation proformer staff (Former Attempted review on Internal Investigation Investigations were as Interview on 3/8/21 with the local Department revealed: -The local DSS office regarding Former Staff (Former Client #2; -The Social Worker's matter but did not has	end record review, the facility egations against health care complete an internal ed to protect clients during cess affecting 1 of 1 audited Staff #5). The findings are: 2/15/21 of the facility's as revealed no Internal				
	revealed: -Went to the facility of with Licensee #1/Dir #1 and Licensee #2/investigate the allegate offering marijuana to -Spoke with Client #1 facility but did not ge	on 1/7/21 at 1:30pm to meet ector/Qualified Professional Executive Director to ation of Former Staff #5 Former Client #2; 1 on 1/7/21 while at the t any significant information ry limited with verbal skills."				
	Licensee #2/Executire -Were out of the cou	1 with Licensee Professional #1 and ve Director revealed: ntry traveling and were to the facility to meet with				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL036-331	B. WING		04/1	6/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC		AVEN DRIVE			
	CLIMMADY CT		A, NC 28052	DDO//DEDIC DLAN OF CODDECTIO	N.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 132	Continued From page	26	V 132			
	to Health Care Perso					
	-Responsible for com investigations at the f wheelhouse;" -Denied DSS came to allegation; -DSS only went to a s allegation was made member offering mari	Professional #1 revealed:				
	-Licensee #1/Director responsible for compl for the facility; -Denied there was an member offering mari -The allegation of a d	juana to Former Client #2;				
	Director/Qualified Pro #2/Executive Director meeting revealed: -When asked if there to present or commer information was provi #1/Director/Qualified #2/Executive Director	with Licensee #1/Executive ifessional #1 and Licensee during the survey exit was additional information into to make, no additional ded by either Licensee Professional #1 or Licensee ss-referenced into 10A				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING		04	R J /16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RRIGHTE	R DAYZ LLC	837 LYN	HAVEN DRIVE			
BRIGITIE	R DATE LLO	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 132	Continued From pag	e 27	V 132			
	NCAC 27G .1701 So Failure to Correct Ty	ope (V293) for a Continued pe A1.				
V 293	27G .1701 Residenti	al Tx. Child/Adol - Scope	V 293			
	children or adolescer free-standing resider intensive, active ther interventions within a shall not be the prima who is not a client of (b) Staff secure mea awake during client shall be continuous a this Section. (c) The population s adolescents who have mental illness, emotion substance-related disco-occurring disorder disabilities. These client meet criteria for in (d) The children or a	atment staff secure facility for onts is one that is a a staff facility that provides apeutic treatment and a system of care approach. It fary residence of an individual the facility. Ans staff are required to be sleep hours and supervision as set forth in Rule .1704 of the facility of the staff facility in Rule .1704 of the staff facility in Rule .17				
	community-based refacilitate treatment; a (2) treatment in (e) Services shall be (1) include indistructure of daily livir (2) minimize the related to functional of (3) ensure safe control behaviors incommanagement with or	om home to a sidential setting in order to and a staff secure setting. designed to: ividualized supervision and ag; ae occurrence of behaviors deficits; ety and deescalate out of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			74. BOILBING			R
		MHL036-331	B. WING		04	/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
PDICUTE	R DAYZ LLC	837 LYNF	IAVEN DRIVE			
BRIGHTE	R DATZ LLC	GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 293	acquisition of adaptive communication, socia (5) support the gaining the skills need intensive treatment set (f) The residential treshall coordinate with	e functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting. atment staff secure facility	V 293			
	the occurrence of beh deficits, ensure safety control behaviors, assadaptive functioning a to step-down to a less affecting 1 of 1 currer 1 audited former client findings are: CROSS REFERENC Competencies of Quarks Professions Based on interview, rubservation, 1 of 2 au (Licensee #1/Director	ecord review, and ty failed to provide ture of daily living, minimize naviors related to functional v and deescalate out of sist in the acquisition of and gaining the skills needed is intensive treatment setting at client (Client #1) and 1 of at (Former Client #2). The E: 10A NCAC 27G .0203 alified Professionals and als (V109) ecord review, and addited qualified professionals v/Qualified Professional #1) the knowledge, skills, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL036-331	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	,	
			AVEN DRIVE	,		
BRIGHTER DAYZ LLC			A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
V 293	Continued From page	e 29	V 293			
	Competencies and Si Paraprofessionals (V Based on interview, robservation, 1 of 7 au (Licensee #2/Executive demonstrate the know required by the popul CROSS REFERENCI assessment and Treat Service Plan (V112) Based on interview and failed to develop and address the needs of audited former client of CROSS REFERENCI Medication Requirem Based on interview, robservation, the facility	ecord review, and udited paraprofessionals ve Director) failed to wledge, skills, and abilities ation served. E: 10A NCAC 27G .0205 atment/Habilitation or und record review, the facility implement strategies to the clients affecting 1 of 1 (Former Client #2). E: 10A NCAC 27G .0209 ents (V118) ecord review, and				
	physician affecting 1 #1).	of 1 current client (Client				
	Based on interview an failed to report all alle personnel, failed to co investigation and failed	e Personnel Registry (V132) and record review, the facility egations against health care complete an internal and to protect clients during areas affecting 1 of 1 audited				
	Incident Reporting Re and B Providers (V36 Based on interview a	E: 10A NCAC 27G .0604 equirements for Category A 67) nd record review, the facility vel III incidents to the LME				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-331	B. WING			R J/16/2021
	ROVIDER OR SUPPLIER	837 LYN	ADDRESS, CITY, STATE IHAVEN DRIVE NIA, NC 28052	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 293	(local management e catchment area wher within 72 hours of beincident. CROSS REFERENC Training on Alternativ Interventions (V536) Based on interview a failed to ensure staff to restrictive intervent audited staff member Director). CROSS REFERENC Training in Seclusion Isolation Time-Out (V Based on interview a failed to ensure staff physical restraint, and 1 of 10 audited staff r #2/Executive Director CROSS REFERENC Location and Exterior Based on interview a was not maintained in attractive manner. CROSS REFERENC Location and Exterior Based on interview a was not maintained in attractive manner. CROSS REFERENC Location and Exterior Based on interview a was not kept free from This deficiency const previously cited 9/29/	ntity) responsible for the e services are provided coming aware of the E: 10A NCAC 27E .0107 es to Restrictive Independent of the services of the services are provided coming aware of the services of the	V 293			
	written by Licensee #					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL036-331	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	
			VEN DRIVE	,	
BRIGHTE	R DAYZ LLC		, NC 28052		
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 (75)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
V 293	Continued From page	e 31	V 293		
		on will the facility take to			
		he consumers in your care?			
	Brighter Dayz (Licens	• ,			
	V109: Brighter Dayz				
	=	NCAC 27G .0203 including			
	ensuring the compete				
	Professional. Specific				
		ive training by a qualified			
	trainer within the 23 d	-			
	 technical knowle cultural awarene 	_			
		88,			
	•				
	0,				
	 interpersonal skil communication s 				
	7. clinical skills.	okiis, and			
	V110: Brighter Dayz v	will comply with all			
	_	NCAC 27G .0204 including			
	ensuring the compete	•			
		ically, the ED (Executive			
	-	training by a qualified trainer			
	within the 30 days of				
	8. technical knowle				
	9. cultural awarene				
	10. analytical skills;	•			
	11. decision-making;				
	12. interpersonal skil				
	13. communication s				
	14. clinical skills.				
	Specifically, QP (Qua	lified Professional) will			
		istories (AWOL (absent			
		EMENT) are inserted in the			
	support/intervention s	section of the PCP (person			
	centered plan). QP w	vill document prior histories			
	and have a meeting v	vhich will serve to establish			
		ill a concern, and develop			
	strategies based on tl	hose concerns. ED will also			
	attend retraining in co	ore areas identified.			
	V112: Brighter Dayz v	will comply with all			
	requirements of 10A I	NCAC 27G .0205 including:			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1ED
			D MINO		R	
		MHL036-331	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTFI	R DAYZ LLC	837 LYNF	IAVEN DRIVE			
		GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	: 32	V 293			
V 293	a. When services at establishment and im treatment/habilitation referred to as the "pla client's presenting prob. Specifically, Clienemployment unless stworkshift. c. Specifically, QP of for historical behavior inserted in the suppor PCP. QP will docume a meeting which will shistories are still a constrategies based on the attend retraining in converse view of the problem of the	re provided prior to the plementation of the or service plan, hereafter in," strategies to address the oblem shall be documented ints will not be able to obtain taff is present for the entire will ensure that interventions (AWOL/ELOPEMENT) are trintervention section of the ent prior histories and have serve to establish which incern, and develop mose concerns. ED will also ore areas identified. Will comply with all NCAC 271g .0209 including the staff have documented ainer in the following topics: insing: Medication packaging instration sall ge what in the following topics: insing: Medication packaging instration sall ge what in the following topics: will comply with all NCAC 27g .0603/.0604 Level II and III incidents are vision of Health Service ME/MCO (local	V 293			
	management entity/m	nanaged care organization) evailing NC DHHS (North				

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PRINTED: 04/29/2021 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3		
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED
					R
		MHL036-331	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	
			HAVEN DRIVE	_, _::	
BRIGHTE	R DAYZ LLC		IIA, NC 28052		
	CUMMA DV CT			DROVIDEDIC DI ANI OF CODDEC	STION
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
V 293	Continued From page	e 33	V 293		
	Carolina Department	of Health and Human			
	-	eporting System (IRIS) within			
	*	AC 27g .0604 stipulated			
	timeframes.				
	e. The agency will I	keep all incident reports on			
		governmental authorities.			
	f. New hires and re	eturning staff will be retrained			
	in incident reporting p	orior to hire/return and			
	annually thereafter.				
	, ,	conduct at least quarterly			
	self-audits to ensure				
		ng Level I,II, & III progress			
	notes to incident repo				
		ider will ensure that in			
		allegations to the HCPR			
	1 -	nel Registry) (24 Hour report			
		port, Incidents involving aff will be reported in IRIS.			
	V536: Brighter Dayz	•			
		NCAC 27E .0107 including:			
	1	choose one Training On			
		ictive Interventions curricula			
		nplete by a qualified trainer			
		27E .0108 . The curriculum			
	will a curriculum appr	oved by the NC			
	DMH/IDD/SAS (ment	al health/intellectual			
	developmental disabi	ility/substance abuse			
	services) on their list	of approved curricula.			
		ensure all newly hired and			
	_	alid Training On Alternatives			
		ntions certificate on file			
	before working and a	-			
		conduct at least quarterly			
	self-audits to ensure				
	V537: Brighter Dayz				
	requirements of NCA				
		part of October POC (plan of			
		te if training for CPI (Crisis			
	Prevention Institute) t	•			
	Documents scanned	resulted in a blank page			

Division of Health Service Regulation

STATE FORM 6899 LVKS11 If continuation sheet 34 of 66

DIVISION	n Health Service Negu	ialion			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL036-331	B. WING		04/16/2021
			•		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DDIGUES	D D AV7 1 1 0	837 LYNH	AVEN DRIVE		
BRIGHTE	R DAYZ LLC	GASTON	A, NC 28052		
	OLIMANA DV OT		-	DDOWDEDIO DI ANI OF CODDECTION	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
IAG		,	1/40	DEFICIENCY)	
V 293	Continued From page	e 34	V 293		
	. •				
	(pg.30 of emailed doo	cuments to DHSR on			
	3/16/21.)				
	V736: Brighter Dayz v	will comply with all			
		C 27G .0303 including:			
	a. The agency will p	•			
	•	ists available for DHSR			
	review.				
	 b. All window sills w 	ill be cleaned as part of			
	monthly self-inspection	on.			
	c. The agency will o	cover any			
		that are broken, until it can			
	be fixed by a professi				
	- ·				
	cannot be hurt/injured				
	V738: Brighter Dayz v				
	requirements of NCA	C 27G .0303 including:			
	a. Cross referenced	d in V736			
	Describe your plans to	o make sure the above			
	happens.				
	Brighter Dayz will:				
	•	Sautifical Fanancia Haalth			
	-	Certified Forensic Health			
	Care Auditor for three				
		y self-audits of the agency to			
	sure compliance with	this POP and any			
	subsequent POC. Th	e self-audits will be in the			
	record.		1		
	Obtain distinct cla	arification from DHSR/other			
	_	uditor regarding treatment			
	=				
	strategies of prior beh				
		coordinator for IRIS			
	training.		1		
	4. Shift MAR respon	nsibility to Executive			
	Director.				
		with newly hired and			
	returning staff about t				
	_	_			
	•	e initial training will be live or			
	live online.				
	Conduct compete	ency-based training with the			
	Qualified Professiona	Land Executive Director	1		

Division of Health Service Regulation

The initial training will be live or live online.

STATE FORM 6899 LVKS11 If continuation sheet 35 of 66

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		MHL036-331	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
		837 LYNH	AVEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTON	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETE	
V 293	Continued From page	e 35	V 293			
	b The agency will no facility until such time POP are fully implem Review on 4/13/21 of Protection written by #1/Director/Qualified 4/13/21 revealed: "What immediate acti ensure the safety of t V109: To ensure the health,	t place residents in the as all the actions in the ented." I the second Plan of Licensee Professional #1 dated ion will the facility take to he consumers in your care?				
	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					
	April,18,2021 highligh section. V110: To ensure the health, Brighter Dayz will tak " Client that is curr	ss; ; ; lls;				

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STATE FORM 6899 LVKS11 If continuation sheet 36 of 66

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
MHL036-331			B. WING		R 04/16/2021
NAME OF D			DEGG OITY OTA	TE 7/D 00DE	1 0 11 10/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA AVEN DRIVE	NE, ZIP CODE	
BRIGHTE	R DAYZ LLC		A, NC 28052		
(V4) ID	OUNDAMEN OF SECURIORS			PROVIDER'S PLAN OF CORRECTION)N (YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 293	Continued From page	: 36	V 293		
	" Client who was w	verking has been discharged			
	Client who was w	orking has been discharged . QP will also ensure that as			
	part of HCPR notificat				
	-	ncident report is filed in IRIS.			
		ttend training on the above			
		by 4/30/21 in the areas			
	below:				
	8. technical knowled				
	9. cultural awarenes	ss;			
	10. analytical skills;				
	11. decision-making;				
	12. interpersonal skil13. communication s				
	14. clinical skills.	Kills, allu			
	V112:				
		safety and welfare of clients			
		e the following actions:			
	" The client who w	as employed has been			
	discharged since Dec				
		ently in our care cannot and			
	will not work without a	•			
		nply with all requirements of			
	10A NCAC 27G .0205	o including: re provided prior to the			
	establishment and im				
		or service plan, hereafter			
		n," strategies to address the			
	·	blem shall be documented.			
		nts will not be able to obtain			
	employment unless st	taff is present for the entire			
	work shift.				
		will ensure that general			
		d to all clients to prevent			
). Any client who had a			
	have a specific super	n the past 12 months will			
		vision plan under the ion of the goal. QP will			
		es and have a meeting			
	which will serve to est				
	histories/behaviors ar				

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STATE FORM 6899 LVKS11 If continuation sheet 37 of 66

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		MHL036-331	B. WING		04	R I/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
DDIOUTE	D D 4 / 7 1 0	837 LYN	HAVEN DRIVE			
BRIGHTE	R DAYZ LLC	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 293	develop strategies bay V118: To ensure the health Brighter Dayz will tak "As of 3/01/21 the Medication Administration and the Execution of th	ased on those concerns. , safety and welfare of clients to the following actions: e staff who was setting up the ration Record (MAR) is no is responsibility has been inversely by the Director. Imply with all requirements of the following ensuring all is documented training by the following topics: Ising: Medication packaging inistration to sall age the weation is sitted weekly by the Executive	V 293			
	Brighter Dayz will tak " The staff who the no longer employed as Brighter Dayz will confide General Statute 1311 Registry. Specifically that allegations agains HCPR within 24 hours the incident. The produce of the incident of the produce of the p	, safety and welfare of clients to the following actions: e allegations was against is at Brighter Dayz. Imply with all requirements of E-256 Health Care Personnel or Brighter Dayz will ensure that staff are reported to the rest of the provider learning of the provider will then submit the 5 feer completing their internal through the staff are reported to the rest of the provider learning of the provider will also submit an IS as part of this process arning of the incident. In safety and welfare of clients the the following actions:				

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STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		MHL036-331	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
PDICUTE	R DAYZ LLC	837 LYNH	AVEN DRIVE		
BRIGHTE	R DATZ LLC	GASTONI	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
V 293	293 Continued From page 38		V 293		
	" 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.				
		ceep all incident reports on			
		governmental authorities.			
		conduct at least quarterly			
	self-audits to ensure				
	_	ng Level I,II, & III progress			
	notes to incident repo V536: Brighter Dayz				
	requirements of 10A				
	-	safety and welfare of clients			
		e the following actions:			
		d as part of October POC			
		Certificate of CPI training is			
	in folder. Documents	scanned resulted in a blank			
	page (pg.30 of emails 3/16/21.)	ed documents to DHSR on			
	Brighter Dayz will ens	sure that all staff have			
	_	t all times. Staff without			
		vill not be allowed to work.			
		CPI certification monthly.			
	V537:	and the and welfare of the set			
	· ·	safety and welfare of clients			
		e the following actions: d as part of October POC			
		Certificate of CPI training is			
		scanned resulted in a blank			
		ed documents to DHSR on			
	3/16/21.)				
	· · · · · · · · · · · · · · · · · · ·	sure that all staff have			

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STATE FORM 6899 LVKS11 If continuation sheet 39 of 66

Division of Health Service Regulation						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL036-331		B. WING		R 04/16/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	•	
			AVEN DRIVE	,		
BRIGHTE	R DAYZ LLC	GASTONI	A, NC 28052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page 39		V 293			
	current CPI training a current CPI training was The ED will monitor CV736: To ensure the health, Brighter Dayz will tak "The broken wind 2/18/21. A photo of the DHSR on 2/18/21. Brighter Dayz will con NCAC 27G .0303 inca. The agency will self-inspection check review. b. All window sills was monthly self-inspection has been updated will c. The agency will cobstruction/windows is self-inspection/windows in the construction/windows is self-inspection/windows in the construction/windows in the current construction/windows in the current construction will construction/windows in the current construction will construct the current curre	at all times. Staff without will not be allowed to work. CPI certification monthly. safety and welfare of clients e the following actions: low has been replaced on the repair was submitted to emply with all requirements of luding: perform monthly lists available for DHSR will be cleaned as part of the on and inspection checklist the this new addition. Cover any that are broken, until it can ional to ensure clients				
	To ensure the health, Brighter Dayz will tak "The window in que photo of the repair wa 2/18/21. Window sills photo was sent to DH Brighter Dayz will cor NCAC 27G .0303 inca. Cross reference V293: To ensure the health, Brighter Dayz will tak Cross reference resp 132, 367, 536, 537, 7	mply with all requirements of luding: to V736 safety and welfare of clients e the following actions: onse to V109,110,112,118,				

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STATEMEN [*]	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
MHL036-331		B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 04/10/2021
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052		
	T	GASTONIA	4, NC 20052		
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 293	Continued From page 40		V 293		
	Care Auditor for three 1. Conduct quarterl sure compliance with subsequent POC. The record. 2. Obtain distinct of providers/Forensic Austrategies of prior before 3. Consult with IRIS training, and specificate after submitting HCPI 4. Shift MAR responsive to the subsequent POC. The live or online. 5. Conduct training returning staff about to subsequent POC. The live or online. 6. Conduct compete Qualified Professional The initial training will documents submitted by auditor. b. The agency will require discuss implementation Review on 4/15/21 of Protection written by #1/Director/Qualified 4/15/21 revealed: "What immediate active ensure the safety of the V109: To ensure the health, Brighter Dayz will taken	y self-audits of the agency to this POP and any he self-audits will be in the arification from DHSR/other aditor regarding treatment haviors/employment. Secondinator for IRIS ally regarding Incident report R. Insibility to Executive with newly hired and his POP and any the initial training will be live or ency-based training with the I and Executive Director. The live or live online. Any to auditor will be signed off the as all the actions in the ented. The ented informal conference to ons made by provider."			

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DIVISION	n nealth Service Regu	lation				
		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
)	
MHL036-331			B. WING		F	6/2021
		INIT 12000-001			1 04/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
PDICUTE	D DAVZ I I C	837 LYNF	IAVEN DRIVE			
BRIGHTE	BRIGHTER DAYZ LLC GASTONIA,					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				,		
V 293	Continued From page	e 41	V 293			
	will not work without a	adequate supervision.				
		vorking has been discharged				
). QP will also ensure that as				
	part of HCPR notifica					
	· ·	ncident report is filed in IRIS.				
		mply with all requirements of				
		3 including ensuring the				
	competency of the Qu					
		ified Professional will receive				
		trainer by April 30, 2021				
	about:	Trainer by 7 pm 60, 2021				
	technical knowled	dae.				
	cultural awarene	_				
	3. analytical skills;	55 ,				
	4. decision-making;					
	5. interpersonal skil					
	6. communication s					
	7. clinical skills.					
		ittend training on PCP's by				
		nting the HOW/SUPPORT				
	section.	3				
	V110:					
	To ensure the health.	safety and welfare of clients				
		e the following actions:				
	,	rently in our care cannot and				
		adequate supervision.				
		vorking has been discharged				
). QP will also ensure that as				
	part of HCPR notifica					
		ncident report is filed in IRIS.				
	_	ttend training on the above				
		by 4/30/21 in the areas				
	below:	-				
	8. technical knowle	dge;				
	9. cultural awarene	_				
	10. analytical skills;					
	11. decision-making;					
	12. interpersonal skil					
	13. communication s					
	14. clinical skills.	•				

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	A. BUILDING:		COMPLETED	
ľ				
MHL036-331	B. WING		R 04/16/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
PRIOUTER RAYTLL O	837 LYNHAVEN DRIVE			
BRIGHTER DAYZ LLC	GASTONIA, NC 28052			
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFO	BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 293 Continued From page 42 V112: To ensure the health, safety and welfard Brighter Dayz will take the following act "The client who was employed has discharged since December 2020. "Client that is currently in our care of will not work without adequate supervis Brighter Dayz will comply with all requir 10A NCAC 27G .0205 including: a. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, he referred to as the "plan," strategies to a client's presenting problem shall be doed be specifically, Clients will not be able employment unless staff is present for the work shift. c. Specifically, QP will ensure that ge supervision is provided to all clients to provided to all c	cions: been cannot and ion. cements of o the cereafter ddress the cumented. ce to obtain che entire coneral corevent had a contract will the CP will cetting and cerns. ce of clients cions: tting up the CR) is no ce been cements of fing all ing by			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	COMPLETED		
	D. WING				R		
		MHL036-331	B. WING		04/16/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
BRIGHTE	R DAYZ LLC		VEN DRIVE				
GASTONI			NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	E	
V 293	Continued From page	e 43	V 293				
V 293	b. Medication admi c. Medication dispond. Medication Stora e. Medication revief. Medication errors f. Medication errors The MAR will be audinorector for conforma V132: To ensure the health, Brighter Dayz will tak " The staff who the no longer employed a Brighter Dayz will cor General Statute 131E Registry. Specifically, that allegations again HCPR within 24 hour the incident. The pro day working report af investigation. The pro locident Report in IRI within 72 hours of lea V367: To ensure the health, Brighter Dayz will tak " The QP will ens reporting allegations Incidents involving all also be reported in IR Brighter Dayz will cor 10A NCAC 27g .0603 d. Ensuring that all reported to DHSR an by the prevailing NC	nistration osal age w ation s ited weekly by the Executive nce with standards. safety and welfare of clients e the following actions: e allegations was against is at Brighter Dayz. mply with all requirements of E-256 Health Care Personnel g Brighter Dayz will ensure est staff are reported to the s of the provider learning of ovider will then submit the 5 riter completing their internal ovider will also submit an S as part of this process arning of the incident. safety and welfare of clients e the following actions: ure that in addition to to the HCPR involving staff , legations against staff will RIS within 72 hours. mply with all requirements of 87.0604 including: Level II and III incidents are d the LME/MCO as required DHHS Incident Reporting the IRIS and 10A NCAC 27g	V 293				
	day working report af investigation. The properties of least National Natio	ter completing their internal ovider will also submit an S as part of this process urning of the incident. safety and welfare of clients e the following actions: ure that in addition to to the HCPR involving staff, legations against staff will RIS within 72 hours. mply with all requirements of 8/.0604 including: Level II and III incidents are d the LME/MCO as required DHHS Incident Reporting the IRIS and 10A NCAC 27g					
	e. The agency will I	frames. keep all incident reports on governmental authorities.					

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Division	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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	MHI 036.331				R	
	MHL036-331				04/16/2021	
			•		•	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		837 LYNI	HAVEN DRIVE			
BRIGHTER DAYZ LLC			IA, NC 28052			
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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(,,,,,,	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPR		
IAG	THE GOLD WORK OF THE	100 IDEITTII TIITO IITI OTTIINI (TOTT)	TAG	DEFICIENCY)		
				,		
V 293	Continued From page	44	V 293			
	oonanaoa i rom page					
	f. The agency will of	conduct at least quarterly				
	self-audits to ensure t	this standard is met				
		ng Level I,II, & III progress				
	notes to incident repo					
	V536: Brighter Dayz					
	requirements of 10A I					
	To ensure the health,	safety and welfare of clients				
	Brighter Dayz will take	e the following actions:				
		d as part of October POC				
		Certificate of CPI training is				
		scanned resulted in a blank				
		ed documents to DHSR on				
	3/16/21.)					
	Brighter Dayz will ens	sure that all staff have				
	current CPI training a	t all times. Staff without				
	_	vill not be allowed to work.				
		CPI certification monthly.				
	V537:	or recrumedation monthly.				
		6 () 16 (6 () (
		safety and welfare of clients				
		e the following actions:				
	" ED was retrained	d as part of October POC				
	submitted to DHSR.	Certificate of CPI training is				
	in folder. Documents	scanned resulted in a blank				
		ed documents to DHSR on				
	3/16/21.)	2 4 4 5 4 6 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				
	,	ours that all staff have				
		sure that all staff have				
		t all times. Staff without				
		vill not be allowed to work.				
	The ED will monitor C	CPI certification monthly.				
	V736:					
	To ensure the health.	safety and welfare of clients				
		e the following actions:				
	,	ow has been replaced on				
		e repair was submitted to				
	· ·	ie repair was submitted to				
	DHSR on 2/18/21.					
	, ,	nply with all requirements of				
	NCAC 27G .0303 incl	luding:				
	a. The agency will p	_				
		lists available for DHSR				

review.

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Division of Health Service Regulation						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	JI CONTROLL	BENTI IGATION NOMBER.	A. BUILDING: _		OOMI EETEB	
					R	
		MHL036-331	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE. ZIP CODE		
			HAVEN DRIVE	,		
BRIGHTE	R DAYZ LLC		IA, NC 28052			
240.15	CLIMMA DV CT		·	DROVIDEDIS DI ANI OF CORDECTIO	NI.	045)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				DEI IOIERO I)		
V 293	Continued From page	e 45	V 293			
	b. All window sills v	will be cleaned as part of				
	1	on and inspection checklist				
	has been updated wit					
	c. The agency will o					
		that are broken, until it can				
		ional to ensure clients				
	cannot be hurt/injured	1.				
		, safety and welfare of clients				
		te the following actions:				
		uestion was fixed/repaired. A				
		as submitted to DHSR on				
	1 -	s have been cleaned, and a				
	photo was sent to DH					
		mply with all requirements of				
	NCAC 27G .0303 incl	•				
	a. Cross reference	to V/36				
	V293:	, safety and welfare of clients				
		e the following actions:				
		onse to V109,110,112,118,				
	132, 367, 536, 537, 7					
	Describe your plans t	to make sure the above				
	happens.					
	Brighter Dayz will:	0 (6 15				
		Certified Forensic Health				
	Care Auditor for three	ly self-audits of the agency to				
	Conduct quarterly sure compliance with					
		he self-audits will be in the				
	record.					
	2. Obtain distinct cla	larification from DHSR/other				
	providers/Forensic A	uditor regarding treatment				
	strategies of prior beh	naviors/employment.				
		S coordinator for IRIS				
		ally regarding Incident report				
	after submitting HCPF					
ľ	4. Shift MAR respor	nsibility to Executive				

Director.

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 or live or live initial training will be live or live or live or live initial training will be live or live			
BRIGHTER DAYZ LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 on live on live or live on live or live on live or live on live or live on live on live on live or live on live or live on lin			
Castonia, NC 28052 Castonia Cas	NAME OF PROVIDER OR SUPPLIE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	PRICHTED DAYZ LLC		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 on live or live or live or live on live	GASTONIA GASTONIA		
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	PREFIX (EACH DEFIC		
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	5. Conduct trareturning staff at subsequent POO live or online. 6. Conduct con Qualified Profess The initial trainin documents subning by auditor. b. The agency facility until such POP are fully im c. Agency will discuss implement of the profession of the professi		

Division of Health Service Regulation

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Division of Health Service Regulation

		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
			D MINIO		R	
		MHL036-331	B. WING		04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTE	R DAYZ LLC		AVEN DRIVE			
		GASTONIA	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	Ē
V 293	Continued From page	e 47	V 293			
	unidentified male afte	er being dropped at the ff. It could not be rmer Client #2 went or what				
	her health needs (Deincontinence, Melator an antipsychotic used with autism, and Stordocumentation on Cli administration records through February, 20 determine if Client #1 as ordered by the phystaff responsible for a	s from December, 2020 21, it was impossible to received her medications ysician. Furthermore, all administration of Client #1's aree month period did not s missing from the				
	offering marijuana to was no evidence of L Director having currer restrictive intervention restraint, and isolation not repair a broken w multiple dead insect of Licensee #1/Director/	applete the necessary allegation of Former Staff #5 Former Client #2. There icensee #2/Executive int training in alternatives to in and seclusion, physical in time-out. The facility did indow and did not remove carcasses. Qualified Professional #1				
	provide the clinical ar required to meet the r #2 resulting in continu This deficiency consti	cutive Director did not and administrative oversight needs of Client #1 and Client used neglect. itutes a Continued Failure to rule violation originally cited				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING: COMPLE			
		A. BOILDING.			
	MHL036-331	B. WING		04	R / 16/2021
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
BRIGHTER DAYZ LLC	837 LYNF	HAVEN DRIVE			
BRIGITIER BATZ EEG	GASTON	IA, NC 28052			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 293 Continued From page	48	V 293			
for serious neglect. A	n administrative penalty of nues to be imposed for				
V 367 27G .0604 Incident R	eporting Requirements	V 367			
level II incidents, excet the provision of billable consumer is on the princidents and level II of to whom the provider 90 days prior to the in responsible for the caservices are provided becoming aware of the besubmitted on a form Secretary. The report in person, facsimile of means. The report shinformation: (1) reporting providentification informat (2) client identification informat (3) type of incidentification informat (4) description of the cause of the incident; (6) other individence or responding. (b) Category A and B missing or incomplete shall submit an update report recipients by the day whenever:	PROVIDERS providers shall report all ept deaths, that occur during e services or while the oviders premises or level III deaths involving the clients rendered any service within cident to the LME tchment area where within 72 hours of e incident. The report shall m provided by the t may be submitted via mail, rencrypted electronic hall include the following evider contact and ion; ication information; eent; of incident; effort to determine the				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL036-331	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTER DAYZ LLC 837 LYNH			AVEN DRIVE			
BRIGHTE	R DATZ LLC	GASTONI	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Continued From page	e 49	V 367			
V 307	information provided erroneous, misleading (2) the provider required on the incide unavailable. (c) Category A and B upon request by the L obtained regarding th (1) hospital recinformation; (2) reports by c (3) the provider (d) Category A and B of all level III incident Mental Health, Develous Substance Abuse Selbecoming aware of the providers shall send a incidents involving a chealth Service Regulbecoming aware of the client death within selfor restraint, the providing mediately, as required. 0300 and 10A NCAC (e) Category A and B report quarterly to the catchment area when The report shall be suby the Secretary via conclude summary information of a level II (2) restrictive in the definition of a level (3) searches of	in the report may be g or otherwise unreliable; or obtains information ent form that was previously a providers shall submit, LME, other information e incident, including: ords including confidential other authorities; and d's response to the incident. B providers shall send a copy reports to the Division of copmental Disabilities and revices within 72 hours of the incident. Category A a copy of all level III client death to the Division of ation within 72 hours of the incident. In cases of the incident. In cases of the incident are death of the death red by 10A NCAC 26C a 27E .0104(e)(18). Be providers shall send a set LME responsible for the deservices are provided ablectronic means and shall remation as follows: errors that do not meet the or level III incident; the treventions that do not meet the or level III incident; a client or his living area; client property or property in	V 307			

Division of Health Service Regulation

STATE FORM 6899 LVKS11 If continuation sheet 50 of 66

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		MHL036-331	B. WING		R 04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	·
BRIGHTE	R DAYZ LLC		AVEN DRIVE A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 367	been no reportable in incidents have occurr meet any of the criteri (a) and (d) of this Rul through (4) of this Par	d; and indicating that there have cidents whenever no ed during the quarter that is as set forth in Paragraphs e and Subparagraphs (1) ragraph.	V 367		
	failed to report all Lev (local management el catchment area where within 72 hours of bed incident. The findings Review on 2/15/21 of	nd record review, the facility rel III incidents to the LME ntity) responsible for the eservices were provided coming aware of the sare:			
	allegation of Former S Former Client #2. Interview on 3/8/21 w the local Department revealed: -There was an investi Staff #5 offering marij -The Social Worker's matter but did not hav #2 because Former C without leave).	impleted regarding an Staff #5 offering marijuana to ith the Social Worker from of Social Services (DSS) gation regarding Former uana to Former Client #2; supervisor investigated the re access to Former Client client #2 was AWOL (absent			
	Interview on 4/5/21 w	ith the local DSS Supervisor			

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STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:	
		MHL036-331	B. WING		R 04/16/2021
NAME OF D			DDDESS SITY STAT	F. 710 CODE	1 04/10/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	
BRIGHTE	R DAYZ LLC		HAVEN DRIVE IIA, NC 28052		
	OUR MADY OF		·		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 367	Continued From page	÷ 51	V 367		
V 307	revealed: -Went to the facility or with Licensee #1/Dire #1 and Licensee #2/E investigate the allegate offering marijuana to -Spoke with Client #1 facility but did not get as Client #1 was "very Attempted interviews unsuccessful as Form missing after going AV 12/20/20. Messages #2's DSS Social Workmother on 2/15/21 and	n 1/7/21 at 1:30pm to meet actor/Qualified Professional executive Director to tion of Former Staff #5 Former Client #2; on 1/7/21 while at the any significant information y limited with verbal skills."	Voor		
	Staff #5 revealed: -Denied ever smoking marijuana to clients; -Already spoke with D-Told DSS the same in the sister facility; -Not sure how this alled Interview on 3/31/21 with 1/Director/Qualified responsible for enterincident reports into Nother Licensed Professistaff to ensure the information of the Licensed Profession of th	facility and only worked at egation ever came about. with Licensee Professional #1 revealed: ring Level II and Level III IC IRIS working alongside ional and the direct care ormation is entered; the facility regarding an			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		MHL036-331	B. WING		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
BRIGHTEI	R DAYZ LLC		IAVEN DRIVE IA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 367	Continued From page 52		V 367		
	Director revealed: -The direct care staff a #1/Director/Qualified I responsible for enterir incident reports into N were reviewed by the -Denied there was an member offering mari -The allegation of a di offering marijuana to a at a sister facility.	Professional #1 was ng Level II and Level III IC IRIS and then the reports Licensed Professional; allegation of a staff juana to Former Client #2; fferent staff member a different client happened			
	Director/Qualified Pro #2/Executive Director meeting revealed: -When asked if there to present or commer information was provide	ith Licensee #1/Executive fessional #1 and Licensee during the survey exit was additional information its to make, no additional ded by either Licensee Professional #1 or Licensee			
	previously cited 9/13/ This deficiency is cross	tutes a recited deficiency, 19, 6/23/20, and 9/29/20. es-referenced into 10 A ope (V293) for a Continued e A1.			
V 536	27E .0107 Client Right.	its - Training on Alt to Rest.	V 536		
	10A NCAC 27E .0107 ALTERNATIVES TO F INTERVENTIONS (a) Facilities shall imp practices that emphase	RESTRICTIVE			

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	PLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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			D MANO		F	
		MHL036-331	B. WING		04/1	6/2021
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	IDDESS CITY STA	TE ZID CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	II E, ZIP CODE		
BRIGHTFI	R DAYZ LLC	837 LYNF	AVEN DRIVE			
2.4.02.		GASTON	A, NC 28052			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 526	0	. 50	V 536			
V 536	Continued From page	9 53	V 536			
	to restrictive intervent	ions.				
		services to people with				
		ding service providers,				
	employees, students	•				
	demonstrate compete	-				
		communication skills and				
		eating an environment in				
	which the likelihood o	f imminent danger of abuse				
	or injury to a person v	vith disabilities or others or				
	property damage is p	revented.				
	(c) Provider agencies	s shall establish training				
		etencies, monitor for internal				
		onstrate they acted on data				
	gathered.	onstruce they deted on data				
		ha competency based				
		be competency-based,				
	include measurable le					
	_ ,	vritten and by observation of				
		jectives and measurable				
	methods to determine	e passing or failing the				
	course.					
	(e) Formal refresher	training must be completed				
	by each service provi	der periodically (minimum				
	annually).					
	(f) Content of the trai	ning that the service				
		ploy must be approved by				
	the Division of MH/DE					
	Paragraph (g) of this					
		strate competence in the				
	following core areas:					
	. ,	and understanding of the				
	people being served;					
		and interpreting human				
	behavior;					
		the effect of internal and				
	external stressors tha	t may affect people with				
	disabilities;	•				
	· ·	or building positive				
	relationships with per	- -				
		cultural, environmental and				
	l (a)	outural, crivirorillicital and	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL036-331	B. WING		1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PDICUTE	R DAYZ LLC	837 LYNF	IAVEN DRIVE			
BRIGHTE	K DATZ LLC	GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	Continued From page	e 54	V 536			
V 330	organizational factors disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in assisting behavior; (8) communical and de-escalating pot and (9) positive behimeans for people with activities which direct behaviors which are used to be a commentation of initical teast three years. (1) Documental (A) who participoutcomes (pass/fail); (B) when and with the decision of the poutcomes (pass/fail); (B) when and with the poutcomes (pass/fail); (C) instructor's (D) The Division review/request this decision in the poutcomes (pass/fail); (E) Trainers shall by scoring 100% on the poutcomes of the preventing, need for restrictive infulcation of the preventing of the prevention of the preventing of the prevention of the pr	that may affect people with the importance of and n's involvement in making life; essing individual risk for tion strategies for defusing tentially dangerous behavior; navioral supports (providing n disabilities to choose ly oppose or replace unsafe). shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name; n of MH/DD/SAS may ocumentation at any time. ations and Training all demonstrate competence esting in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an gram.	V 330			

Division of Health Service Regulation

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFI	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING				A. BOILDING		_	
BRIGHTER DAYZ LLC 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 837 LYNHAVEN DRIVE (BASTONIA, NC 28052 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			MHL036-331	B. WING			
BRIGHTER DAYZ LLC GASTONIA, NC 28052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROVIDER	OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CASTONIA, NC 28052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			837 LYNHA	AVEN DRIVE			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	BRIGHTER DAYZ	LLC	GASTONIA	A, NC 28052			
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPL	ETE
V 536 Continued From page 55 V 536	V 536 Contin	nued From page	e 55	V 536			
(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/fall); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation on any time. (k) Qualifications of Coachess: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached.	(4) service approvite Sub (5) shall in (A) (B) course (C) perform (D) (6) teachined intervereview (7) aimed need f annua (8) instruct (j) Ser docum trainin (1) (A) outcor (B) (C) (2) reques (k) Qu (1) require (2)	The content the provider plans the provider providers the providers t	to of the instructor training the sto employ shall be sion of MH/DD/SAS pursuant of of this Rule. Instructor training programs not limited to presentation of: ing the adult learner; in teaching content of the revaluating trainee ion procedures. Call have coached experience or or experience or ex	V 536			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		MHL036-331	B. WING		R 04/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BRIGHTER DAYZ LLC			VEN DRIVE		
			, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 536	Continued From page	e 56	V 536		
	competence by comp	letion of coaching or			
	failed to ensure staff to restrictive intervent	nd record review, the facility were trained in alternatives ions affecting 1 of 10 s (Licensee #2/Executive			
	Director's record rever- Hire date 8/1/18; -Training certificate for intervention training the Intervention program expiration date 10/23.	or alternatives to restrictive nrough Nonviolent Crisis issued 10/23/19 with /20; ation regarding training for			
	Director revealed: -Was trained in Nonvi	with Licensee #2/Executive olent Crisis Intervention.			
	exit meeting revealed -Not sure why License	Professional #1 and e Director during the survey			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		MHL036-331	B. WING	<u>.</u>	04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	•	
			HAVEN DRIVE	_,		
BRIGHTE	R DAYZ LLC	GASTON	IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETE	E
V 536	Continued From page	÷ 57	V 536			
	Crisis Intervention wa training was complete	s not provided but the ed in October, 2020.				
	This deficiency consti previously cited 9/29/	tutes a recited deficiency, 20.				
	_	es-referenced into 10A ope (V293) for a Continued se A1.				
V 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OL (a) Seclusion, physic time-out may be empty been trained and have competence in the protect to these procedures. Staff authorized to emprocedures are retrain competence at least at (b) Prior to providing a disabilities whose treatincludes restrictive into service providers, empoly to the service providers, empoly training is completed demonstrated. (c) A pre-requisite for demonstrating competence and shall not use the straining is preventing, the need for restrictive to the service providers.	CAL RESTRAINT AND JT al restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including ployees, students or olete training in the use of straint and isolation time-out se interventions until the and competence is taking this training is stence by completion of reducing and eliminating e interventions. be competency-based,				

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DIVISION	n Health Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		MIII 000 004	B. WING		R
		MHL036-331	B. W		04/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		837 I YNH.	AVEN DRIVE		
BRIGHTE	R DAYZ LLC		A, NC 28052		
			T, NC 20032	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 537	Continued From page	e 58	V 537		
	measurable testing (w	vritten and by observation of			
		pjectives and measurable			
	-	e passing or failing the			
	course.	e passing or family the			
		training must be completed			
		training must be completed			
	-	der periodically (minimum			
	annually).				
	(f) Content of the trai				
		ploy must be approved by			
	the Division of MH/DE				
	Paragraph (g) of this				
		ng programs shall include,			
	but are not limited to,	•			
	` '	formation on alternatives to			
	the use of restrictive i				
		on when to intervene			
	(understanding immin	nent danger to self and			
	others);				
	(3) emphasis of	n safety and respect for the			
	rights and dignity of a	II persons involved (using			
	concepts of least rest	rictive interventions and			
	incremental steps in a	an intervention);			
	(4) strategies fo	or the safe implementation			
	of restrictive intervent	ions;			
	(5) the use of e	mergency safety			
	interventions which in	clude continuous			
	assessment and mon	itoring of the physical and			
		ing of the client and the safe			
		ghout the duration of the			
	restrictive intervention				
	(6) prohibited p				
		trategies, including their			
	importance and purpo				
		tion methods/procedures.			
	(h) Service providers				
		al and refresher training for			
	at least three years.	ara renestici trattility to			
		tion shall include:			
	\ <i>\</i>	ated in the training and the			
	(A) WITO Particip	awa in uie uaning and uie	1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL036-331	B. WING		R 04/16/2021	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 0 11 10 20 21	
			AVEN DRIVE			
BRIGHTE	R DAYZ LLC		A, NC 28052			
	OLUMANA DV OT		<u> </u>	DDOV/DEDIO DI ANI OF GODDECTIO	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	e 59	V 537			
	outcomes (pass/fail);					
		vhere they attended; and				
	(C) instructor's					
		n of MH/DD/SAS may				
		ocumentation at any time.				
	(i) Instructor Qualifica	ation and Training				
	Requirements:					
	` '	all demonstrate competence				
		esting in a training program				
	need for restrictive int	reducing and eliminating the				
		all demonstrate competence				
	` '	esting in a training program				
		eclusion, physical restraint				
	and isolation time-out					
		all demonstrate competence				
	` '	grade on testing in an				
	instructor training pro	-				
	(4) The training					
		nclude measurable learning				
		le testing (written and by				
		ior) on those objectives and				
		to determine passing or				
	failing the course.	. 3				
	_	t of the instructor training the				
	service provider plans					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6	i) of this Rule.				
		instructor training programs				
	shall include, but not	be limited to, presentation				
	of:					
		ng the adult learner;				
	' '	r teaching content of the				
	course;					
	, ,	of trainee performance; and				
	` '	ion procedures.				
	(7) Trainers sha	all be retrained at least				
	_	strate competence in the use				
	of seclusion, physical	restraint and isolation				

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Division of	of Health Service Regu	ilation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		COMPLETED	
				R		
		MHL036-331	B. WING		04/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		837 LYN	HAVEN DRIVE			
BRIGHTE	R DAYZ LLC		IIA, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
V 537	Continued From page	e 60	V 537			
	time-out, as specified Rule.	I in Paragraph (a) of this				
		all be currently trained in				
	CPR.	an be currently trained in				
		all have coached experience				
	•	f restrictive interventions at				
		a positive review by the				
	coach.	-11.4				
		all teach a program on the rventions at least once				
	annually.	ivertions at least office				
	_	all complete a refresher				
	instructor training at I					
	(k) Service providers					
	documentation of initial and refresher instructor					
	training for at least three years.					
	` '	tion shall include:				
		pated in the training and the				
	outcome (pass/fail);	where they attended; and				
	(B) when and v(C) instructor's	where they attended; and				
		n of MH/DD/SAS may				
		ocumentation at any time.				
	(I) Qualifications of C					
	(1) Coaches sh	nall meet all preparation				
	requirements as a tra	niner.				
	` '	nall teach at least three				
	times, the course whi					
	` '	nall demonstrate				
	competence by comp train-the-trainer instru	-				
	(m) Documentation s					
	preparation as for tra					
	F. 5P					
	This Rule is not met					
	Based on interview a	nd record review, the facility				1

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R		
		MHL036-331	B. WING		ı	6/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	· · ·	
BRIGHTER DAYZ LLC 837 LYNHAV			VEN DRIVE			
BRIGHTE	CDATE LLO	GASTONIA	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	Continued From page 61		V 537			
	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 10 A					
	<u>-</u>	ope (V293) for a Continued				
V 736	-	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 EXTERIOR REQUIR (c) Each facility and it maintained in a safe,	EMENTS				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BUILDING.		R			
		MHL036-331	B. WING		04/16/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BRIGHTE	BRIGHTER DAYZ LLC 837 LYNHAVEN DRIVE						
GASTONI			A, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
V 736	6 Continued From page 62		V 736				
	manner and shall be odor.	kept free from offensive					
		nd observation, the facility n a clean, orderly, safe, and					
	#2's bedroom). The beginner which was broken the bottom half of the windowpane was appediameter hole with jag. The 6 pane window wroom and was backed window which was interpreted bedroom); -Broken blind in bedrobedroom); -Broken curtain rod beginning the front of the	y revealed: droom #1 (Former Client broken windowpane was on e over three, and the one en was the middle pane on window. The hole in the broximately a four inch gged edges of plexiglass. It was on the interior of the d by a solid glass storm tact; boom #2 (Client #1's medroom #3 (single room facility).					
	#1/Director/Qualified -Was aware of the bro Client #2's bedroom; -Had previously conta broken window; -Did not follow up to e was repaired but will	Professional #1 revealed: oken window in Former acted a repairman to fix the ensure the broken window do so today.					
	Interview on 3/31/21 v #1/Director/Qualified	with Licensee Professional #1 revealed:					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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; -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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) TAG 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 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			A. Boilbirto.	A. BUILDING.	
BRIGHTER DAYZ LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		MHL036-331	B. WING	 	
CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	E OF PROVIDER OR SUPPLIER	PPLIER STREET	TADDRESS, CITY, STATE	E, ZIP CODE	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCISES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	GHTER DAYZ LLC	837 LY			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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; -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		GASTO	ONIA, NC 28052		
-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	EFIX (EACH DEFICIENCY	DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERT	D BE COMPLETE
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	/ 736 Continued From page	Continued From page 63			
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	-Not sure how the wind bedroom broke; -Sent a picture of the resurveyors on 2/18/21 awas brought to his atte the picture of the repair. Will make sure there windows moving forward-Had originally reporter repair shop around James follow up regarding the repair the window and	ow the window in Former Client #2's oke; ure of the repaired window to DHSR in 2/18/21 after the broken window it to his attention again and will resend of the repaired window again now; sure there are no more broken oving forward; ally reported the broken window to the around January, 2021 and did not garding the broken window; shop was to come to the facility to indow and they did not come; ow up regarding the broken window surveyors were present and then and the window was repaired the next 1). 13/31/21 with Licensee #2/Executive ealed: 15 e for house inspections monthly and and the house and looks around; 16 Manager completed the house and Licensee #2/Executive Director find the House Manager; 17 d to clarify who completed house the question was not answered; 18 v in Former Client #2's bedroom was a to Former Client #2's admission 18 little pebbles around the facility; 19 a ding; 19 aper broke the window; 10 the window in Former Client #2's as delayed because it "slipped through and the repairman did not come out.			

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Licensee #2/Executive Director during the survey

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL036-331	B. WING		04	R / 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTE	R DAYZ LLC	837 LYN	HAVEN DRIVE			
BRIGITIE	N DAIZ ELO	GASTO	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 736	to present or commer information was prov #1/Director/Qualified #2/Executive Director This deficiency const previously cited 11/13 This deficiency is cro NCAC 27G .1701 Sc Failure to Correct Typ	was additional information into make, no additional ided by either Licensee Professional #1 or Licensee r. itutes a recited deficiency, 3/20. ss-referenced into 10 A ope (V293) for a Continued one A1.	V 736			
V 738	rodents. This Rule is not met	3 LOCATION AND EMENTS kept free from insects and as evidenced by:	V 738			
	was not kept free from Observation on 2/15/11:30am of the front -Numerous insect can the two front windows overlooking the front -The insect carcasse beetle.	of the facility revealed: rcasses in the windowsills of s furthest from the front door porch; s appeared similar to a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		COMPLETED	
				R	
MHL036-331		B. WING		04/16/2021	
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			HAVEN DRIVE	,	
BRIGHTE	R DAYZ LLC		IIA, NC 28052		
240.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	<u> </u>	DROVIDEDIS DI ANI CE CORRECTIO	N OFF
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
V 738	Continued From page	e 65	V 738		
	-Dead bugs are on th	e outside of the windows;			
	-A local pest control of	company came to the facility			
	and treated a hornet's	s nest in the window;			
	-The landscapers are	responsible to dust off the			
	windows;				
	-The staff clean the ir	nside of the facility.			
	1.4				
	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 clarif	y who completed house			
	• • • • •	tion was not answered;			
	-"Maybe we can spra				
		nultiple dead bug carcasses			
	are cleaned;	an the outside of the facility			
	·	e inside of the facility.			
	and the stan clean the	e maide of the facility.			
	Interviews on 4/8/21	with Licensee			
	#1/Director/Qualified				
	Licensee #2/Executiv	e Director during the survey			
	exit meeting revealed				
		was additional information			
		nts to make, no additional			
		ded by either Licensee			
	#1/Director/Qualified #2/Executive Director	Professional #1 or Licensee			
	#Z/Executive Director	•			
	This deficiency consti	itutes a recited deficiency,			
	previously cited 11/13	•			
	-				
		ss-referenced into 10A			
		ope (V293) for a Continued			
	Failure to Correct Typ	pe A1.			

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