STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on March 21, 2024. The complaint was unsubstantiated (intake #NCNC00214440). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the	V 111		

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V 111	Continued From page 1 treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure an admission assessment was completed prior to delivery of services for 2 of 3 audited clients (#1 and #4). The findings are: Review on 03/20/24 of the facility "Comprehensive Clinical Assessment (CCA)" policy revealed: - Policy: 1.0 Clients determined to be eligible to receive services from BLC (Bright Light Counseling) shall have an assessment completed by a licensed professional within three business days" Review on 03/20/24 of client #1's record revealed: - 16 year old female. - Admission date of 02/02/24. - Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Adjustment Disorder and Depressed Mood. - Assessment of client from facility prior to admission. - No facility admission assessment prior to the	V 111		

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V 111	Continued From page 2 delivery of services. Review on 03/20/24 of client #4's record revealed: - 15 year old female. - Admission date of 02/05/24. - Diagnoses of PTSD, DMDD, Major Depressive Disorder and Adjustment Disorder. - Assessment of client from facility prior to admission. - No facility admission assessment prior to the delivery of services. Interview on 03/21/24 the Licensee/Licensed Professional stated: - She understood facility admission assessments should be completed prior to the delivery of services.	V 111		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;	V 112		

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BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 112	Continued From page 3 (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to develop and implement treatment strategies for 2 of 3 clients audited (#3 and #4). The findings a Finding #1: Review on 03/20/24 of client #3's record revealed: - 16 year old female. - Admission date of 12/29/23. - Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit Hyperactivity Disorder and Post Traumatic Stress Disorder (PTSD). - 01/16/24 acute care hospital admission for suicidal ideations. - No documentation of participation in therapy. Review on 03/20/24 of client #3's Person-Centered Profile (PCP) dated 12/19/23 revealed: Goal #1: Maintain health and safety. - How- Participate in therapy	V 112		

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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V 112	Continued From page 4 - Who is responsible - therapist - Service and Frequency - as needed. Goal #2: History of physical aggression during moments and/or periods of emotional Dysregulation. - How- Participate in therapy - Who is responsible - therapist - Service and Frequency - as needed. Interview on 03/19/24 client #3 stated: - She was admitted to the facility approximately 3 months ago. - She does not see a therapist. Finding #2: Review on 03/20/24 of client #4's record revealed: - 15 year old female. - Admission date of 02/05/24. - Diagnoses of PTSD, DMDD, Major Depressive Disorder and Adjustment Disorder. Review on 03/20/24 of client #4's PCP dated 01/26/24 revealed: "Smart Goal #1: [Client #4] will work alongside of her therapeutic supports in a level 3 group home residential setting to achieve mental health and behavioral stability. [Client #4] will reduce overall frequency, intensity, & duration of her mental & behavioral health symptoms such as depression, anxiety, anger, impulsivity & defiance to help improve overall daily living skills, decision making skills in order to make better choices & decrease at-risk behaviors..." - Intervention Provider: "Level 3 Residential Facility will provide necessary therapeutic treatment and supports to client to achieve mental health and behavioral stability. Use eco-structural therapy, emotionally focused therapy, and trauma focused treatment address	V 112		

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V 112	Continued From page 5 the functions of behavior to decrease likelihood of recidivism..." - Who is responsible for intervention-providers: Clinician/Therapist, Level 3 and Caregiver/Family. - Frequency and duration - Daily and Family Centered Treatment. Interview on 03/19/24 client #4 stated: - She had resided at the facility for approximately 1 month. - She had not received therapy while at the facility. Interview on 03/21/24 the Licensee/Licensed Professional stated: - There had been an issue with obtaining sexualized therapy. - She communicated with the Local Management Entity to discuss treatment options. - She had communicated with client #4's mother regarding assessment and treatment schedule. - She would review therapy indicated in both client PCPs.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.	V 114		

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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V 114	Continued From page 6 (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 03/19/24 of facility records from December 2024 thru March 19, 2024 revealed: - Fire drills documented on 12/06/23 at 12:30am, 01/16/24 at 2am and 02/01/24 at 11:18pm. - No documented disaster drills. Interview 03/19/24 client #1 stated: - She had resided at the facility for approximately 1 month. - She had not participated in any fire or disaster drills. Interview 03/19/24 client #4 stated: - She had resided at the facility for approximately 1 month. - She had not participated in any fire or disaster drills. Interview on 03/19/24 and 03/20/24 the Licensee/Licensed Professional stated: - The facility admitted the first client on 12/04/23. - The facility had a 2nd shift from approximately 3pm to 11pm and 3rd shift from 10:30pm/11pm until 8:30am - Monday thru Friday. - The facility had 12 hour weekend shifts from 8:30am to 8:30pm and 8:30pm until 8:30am. - She understood fire and disaster drills needed	V 114		

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V 114	Continued From page 7 to be conducted on all weekday and weekend shifts quarterly.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 8 This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 1 of 3 audited clients (#4). The findings are: Review on 03/20/24 of client #4's record revealed: - 15 year old female. - Admission date of 02/05/24. - Diagnoses of PTSD, DMDD, Major Depressive Disorder and Adjustment Disorder. Review on 03/20/24 of client #4's medication orders revealed: - Vitamin D3 (treats vitamin D deficiency) 50 micrograms (mcg) (2,000 units) - take daily. Review on 03/19/24 and 03/20/24 of client #4's February 2024 and March 2024 MARs revealed: February 2024 - Transcribed entry for Vitamin D3 50mcg (2,000 unit) tablet take daily in the morning. - No staff initials to indicate the medication had been administered as ordered. March 2024 - Transcribed entry for Vitamin D3 50mcg (2,000 unit) tablet take daily in the morning. - Staff initials to indicate the medication was administered daily. Observation on 03/19/24 of client #4's medications revealed: - Calcium dietary supplement 600 milligrams with Vitamin D3 20mcg (800 units).	V 118		

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V 118	Continued From page 9 - No Vitamin D3 50mcg (2,000 unit) available for administration in client #4's medications. Interview on 03/19/24 client #4 stated she did not know if she took Vitamin D3 daily. Interview on 03/19/24 staff #8 stated he would follow up on the Vitamin D3 for client #4. Interview on 03/19/24 the Associate Professional stated: - Client #4 received the calcium with Vitamin D3. - She was not aware the Vitamin D3 dosage in the calcium supplement was less than prescribed by the physician. Interview on 03/21/24 the Licensee/Licensed Professional stated: - There had been issues with medications at the facility. - She would follow up on identified medication concerns. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be	V 293		

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 293	Continued From page 10	V 293		

awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section.
(c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services.
(d) The children or adolescents served shall require the following:
(1) removal from home to a community-based residential setting in order to facilitate treatment; and
(2) treatment in a staff secure setting.
(e) Services shall be designed to:
(1) include individualized supervision and structure of daily living;
(2) minimize the occurrence of behaviors related to functional deficits;
(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;
(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and
(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.
(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 293	Continued From page 11	V 293		

This Rule is not met as evidenced by:
Based on record reviews, observation and interview the facility's residential staff failed to coordinate with other agencies to meet the needs for 2 of 3 audited clients (#1 and #3). The findings are:

Finding #1:
Review on 03/20/24 of client #1's record revealed:
- 16 year old female.
- Admission date of 02/02/24.
- Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Adjustment Disorder and Depressed mood.
- 03/04/24 order for Epipen (treats allergic reactions) use.
- No documentation client #1 had an Epipen for use at school.

Review on 03/19/24 and 03/20/24 of client #1's February 2024 and March 2024 Medication Administration Records revealed the following transcribed entry:
- Epinephrine (Epipen) - inject 1 pen as needed for severe allergic reaction to shellfish.

Observation on 03/19/24 at approximately 12:50pm revealed:
- Client #1 was at school and not at the facility.
- Client #1's medications at the facility contained an Epipen dispensed on 12/15/23.

Finding #2:

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 293	Continued From page 12 Review on 03/20/24 of client #3's record revealed: - 16 year old female. - Admission date of 12/29/23. - Diagnoses of DMDD, Attention Deficit Hyperactivity Disorder and Post Traumatic Stress Disorder. Review on 03/21/24 of a signed physician order for client #3 dated 03/15/24 revealed: - Physician authorization for medication at school: 2023-2024. - Ventolin (treats asthma) 2 puffs every 4 hours as needed for shortness of breathe and wheezing. Observation on 03/19/24 at approximately 1:15pm revealed: - Client #3 was at school and not at the facility. - Client #3's medications at the facility included 2 Ventolin inhalers with label directions for one at school and one at home. Interview on 03/19/24 staff #2 stated client #3 did not take the ventolin inhaler to school. Interview on 03/19/24 and 03/21/24 the Licensee/Licensed Professional stated: - A Child and Family Team meeting was recently completed to allow client #3 to take her inhaler to school. - Client #3's doctor had ordered the inhaler use at school. - She would ensure issues with medications are followed up on.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing	V 296		

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 296	Continued From page 13 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 296	Continued From page 14 child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure at least two direct care staff were present for one, two, three or four children or adolescents. The findings are: Finding #1: Review on 03/20/24 of client #1's record revealed: - 16 year old female. - Admission date of 02/02/24. - Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Adjustment Disorder and Depressed Mood. Review on 03/20/24 of client #2's record revealed: - 15 year old female. - Admission date of 02/23/24. - Diagnoses of Major Depressive Disorder and Attention Deficit Hyperactivity Disorder (ADHD) Combined Type. Review on 03/20/24 of client #3's record revealed: - 16 year old female. - Admission date of 12/29/23. - Diagnoses of DMDD, ADHD and Post Traumatic Stress Disorder (PTSD).	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 296	Continued From page 15 Review on 03/20/24 of client #4's record revealed: - 15 year old female. - Admission date of 02/05/24. - Diagnoses of PTSD, DMDD, Major Depressive Disorder and Adjustment Disorder. Interview on 03/19/24 staff #2 stated: - She began working at the facility in December 2023. - She worked 3rd shift from 10pm until 8:30am or 9am. - There were 4 clients at the facility. - She worked the previous night by herself. - One staff worked during the overnight sleep hours. Finding #2: Review on 03/20/24 of former client (FC) #5's record revealed: - 14 year old female. - Admission date of 12/15/23. - Diagnoses of Adjustment Disorder and Disruptive Mood Dysregulation Disorder (DMDD). - Discharge date 01/23/24. - FC #5 was discharged to a local juvenile detention center. Review on 03/20/24 of an incomplete North Carolina Incident Response Improvement System (IRIS) report dated 01/22/24 at 7:55pm revealed: - FC #5 had been escalated during the day. - Staff #6 had went to check on FC #5 in her bedroom at 7:55pm. - FC #6 had eloped from her window. - Local law enforcement was notified. - Staff #6 was the only staff supervising FC #5. - FC #5 was at the local law enforcement office at approximately 8:13pm.	V 296		

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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V 296	Continued From page 16 Interview on 03/20/24 staff #6 stated: - She recalled the elopement of FC #5 on 01/22/24. - FC #5 had been agitated throughout the day. - She was checking on her frequently at least every 15 minutes or less. - FC #5 had eloped from the window. - She called 911. - FC #5 was the only client at the facility. - She was the only staff with FC #5 when she eloped on 01/22/24. Interview on 03/19/24 and 03/21/24 the Licensee/Licensed Professional stated: - The first client was admitted in December 2023. - The service definition through the Local Management Entity was 1 staff to 4 clients. - She was having 3 staff in the afternoons now. - There was one staff during the overnight sleeping hours. - She was not aware of the requirement from licensure of 2 staff present for one, two, three or four children or adolescents. - She would make the necessary adjustments to ensure the facility was incompliance with the minimum staffing requirements per rule.	V 296		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident;	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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V 366	Continued From page 17	V 366		

(2) determining the cause of the incident;
(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 366	Continued From page 18	V 366		

who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 366	Continued From page 19 treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to document their response to a level II incident. The findings are: Review on 03/20/24 of client #4's record revealed: - 15 year old female. - Admission date of 02/05/24. - Diagnoses of Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Major Depressive Disorder and Adjustment Disorder. - Client #4 was had a local hospital stay Review on 03/19/24 thru 03/21/24 of facility records revealed: - No documentation for local law enforcement involvement during a behavior and subsequent Involuntary Commitment (IVC) of client #4 on 03/07/24. Interview on 03/19/24 staff #7 stated: - He recalled the 03/07/24 incident with client #4. - Local law enforcement was contacted due to client #4's behavior. - Law enforcement transported client #4 to the local hospital.	V 366		

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 366	Continued From page 20 - He went to the magistrate's office to take out IVC papers for client #4 Interview on 03/19/24 and 03/21/24 the Licensee/Licensed Professional stated: - She would send the 03/07/24 incident report for client #4. - She had a serious computer issue and this caused issues with retrieving the information from the facility software program regarding incident reports. - She would address the issue identified with documenting incident report. No incident was provided for the 03/07/24 incident report for client #4 at exit of survey.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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V 367	Continued From page 21	V 367		

(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a

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	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

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BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 367	Continued From page 22 report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Review on 03/20/24 of incomplete North Carolina Incident Response Improvement System (IRIS) reports revealed: 01/22/24 at 7:55pm: - Former Client (FC) #5 eloped out of her	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-273	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT LIGHT RESIDENTIAL	18 LOGAN ROAD CASTLE HAYNE, NC 28429

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V 367	Continued From page 23	V 367		

bedroom window and local law enforcement was notfied.
- No documentation the IRIS report was officially submitted as required.

01/23/24 at 10:40am:
- FC #5 eloped from the facility and local law enforcement were contacted for assistance.
- No documentation the IRIS report was officially submitted as required.

01/10/24 at 3:30pm:
- Client #3 eloped from the facility and local law enforcement were contacted for assistance.

Review on 03/19/24 thru 03/21/24 of facility records revealed:
- No IRIS report completed for local law enforcement involvement during a behavior and subsequent Involuntary Commitment of client #4 on 03/07/24.

Interview on 03/19/24 and 03/21/24 the Licensee/Licensed Professional stated:
- She was not aware the IRIS reports had not been officially submitted as required.
- She had a serious computer issue and this caused issues with retrieving the information.
- She would address the issue with submitting the IRIS reports.