STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-931	A. BUILDING: _____ B. WING _____	R 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSIDE HOMES INC	4133 WHITE PINE DRIVE RALEIGH, NC 27612

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V 000	INITIAL COMMENTS An annual and follow-up survey was completed on March 17, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000	Brightside Raleigh	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105	V105 Governing Body Policies As of 3/25/25 the facility administrator has completed the application process to obtain a CLIA waiver.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: E Louise Moon BSN, RS — TITLE — (X6) DATE: 3/25/25

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges; (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement adoption of standards that ensured operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument and Injectable pen including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are: Review on 3/13/25 of the facility's records revealed: -There was no documentation or evidence of a CLIA waiver. Review on 3/13/25 of client #1's record revealed: -Admission date of 7/16/24. -Diagnoses of Major Depressive Disorder; Acute Ischemic Left MCA (Middle Cerebral Artery) Stroke; Polysubstance Abuse; Antisynthetase Syndrome (ASS); Anxiety; Chronic Pain (back shoulder, bilateral knee); Chiari Malformation S/P (status post) Decompression (1985); Chronic Low Blood Pressure; Morbid Obesity. -Physician's orders dated 7/19/24: Wegovy (weight loss) - 1.7 milligrams (mg) - Inject 0.75 ml subcutaneously weekly. Review on 3/13/25 of client #2's record revealed: -Admission date of 8/30/24. -Diagnoses of Schizophrenia - Unspecified; Asthma; GERD; Hyperlipidemia; Sleep Apnea; Diabetes. -Physician's orders dated 1/6/25. Accu-Chek Guide - Use to test blood sugar	V 105		

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V 105	Continued From page 3 once a week. Review on 3/13/25 of client #1's Medication Administration Record for the months of January 2025 through March 13, 2025 revealed: -Client #1's injections were administered and recorded weekly. Review on 3/13/25 of client #2's Medication Administration Record for the months of January 2025 through March 13, 2025 revealed: -Client #2's blood sugar levels were checked and recorded once weekly. Interview on 3/13/25 with the Administrator revealed: -She was aware that she needed the CLIA waiver. -She was aware that client #2 received blood sugar checks. -She began the CLIA waiver process but did not follow through. -She confirmed the facility failed to have a CLIA waiver to complete blood sugar checks and injections.	V 105		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the	V 107	V107 Personnel Requirements The staff person has contacted the school she attended and requested a copy of her diploma as of 3/25/25. Going forward the administrator will ensure that any future applicants have proof of education prior to the initiation of employment.	

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V 107	Continued From page 4 supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by:	V 107		

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V 107	Continued From page 5 Based on record review and interviews, the facility failed to complete personnel records affecting one of three audited staff (#1). The findings are: Review on 3/13/25 of the personnel record for staff #2 revealed: -Date of hire was 5/11/20. -Hired as a Health Care Professional. -No educational verification. Interview on 3/13/25 with the Administrator revealed: -She was responsible for staff personnel records. -She previously had documentation of staff #1's education. -She was not sure why documentation of client #1's education was not in the personnel record. -She confirmed that she did not have documentation of client #1's education.	V 107		
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	V 112	V112 Assessment/Treatment/Hab Plan The QP has sent the document to the guardian as of 3/18/25 for the signature. Going forward if a guardian is unable to attend the treatment update, then the QP will send the completed update to the guardian for signature immediately after the meeting.	

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V 112	Continued From page 6 annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have an annually updated treatment plan with written consent or agreement by the client or responsible party affecting one of three clients (#2). The findings are: Review on 3/13/25 of client #1's record revealed: -Admission date of 7/16/24. -Diagnoses of Major Depressive Disorder; Acute Ischemic Left MCA (Middle Cerebral Artery) Stroke; Polysubstance Abuse; Antisynthetase Syndrome (ASS); Anxiety; Chronic Pain (back shoulder, bilateral knee); Chiari Malformation S/P (status post) Decompression (1985); Chronic Low Blood Pressure; Morbid Obesity. -Treatment plan effective 7/29/24. -There was not a signature or written consent from the guardian or responsible party on client #1's treatment plan. Interview on 3/13/25 with the Qualified	V 112		

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V 112	Continued From page 7 Professional revealed: -She was responsible for obtaining a signature or written consent from the guardian or responsible party on client #1's treatment plan. -She confirmed that there was not a signature or written consent from the guardian or responsible party on client #1's treatment plan. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;	V 113	V113 Client Records As of 3/18/25 the consents have Been forwarded to the guardian for signature. Going forward if a guardian has not returned the consents prior to admission, then the administrator will not admit the client until the signed consents have been received.	

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V 113	Continued From page 8 (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain required documentation in the client records affecting one of three clients (#1). The findings are: Review on 3/13/25 of client #1's record revealed: -Admission date of 7/16/24. -Diagnoses of Major Depressive Disorder; Acute Ischemic Left MCA (Middle Cerebral Artery) Stroke; Polysubstance Abuse; Antisynthetase Syndrome (ASS); Anxiety; Chronic Pain (back shoulder, bilateral knee); Chiari Malformation S/P (status post) Decompression (1985); Chronic Low Blood Pressure; Morbid Obesity. -No documentation of a signed statement from the client granting permission to seek emergency care.	V 113		

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V 113	Continued From page 9 Interview on 3/13/25 with the Administrator revealed: -She did not "realize" that the permission to seek emergency care form was not signed by client #1's guardian. -She was responsible for obtaining the guardian's signature. -She acknowledged that the permission to seek emergency care form was not signed by the guardian.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans 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 the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.	V 114	V 114 Emergency Plans and Supplies As of 3/25/25 staff was re-inserviced on procedures and protocols for conducting fire & disaster drills. Each will be completed by the residential staff on no less than a monthly basis and will be completed on all shifts within the quarter. The administrator will ensure drills have been completed on a monthly basis and will co-sign the form after the drill is completed..	

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V 114	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were done quarterly on each shift. The findings are: Review on 3/13/25 of the facility's disaster drill log from April 2024 - March 2025 revealed: -There were no disaster drills conducted during the 2nd quarter (April, May, June) of 2024. -There were no disaster drills conducted during the 4th quarter (October, November, December) of 2024. Interviews on 3/13/25 with clients #1, #2, and #3 revealed: -Staff #1 conducted fire and disaster drills. -Clients #1, #2, and #3 reported that they were escorted outside in the front yard and away from the facility during a fire drill. -Clients #1, #2, and #3 reported that they went into the facility's hallway in the event of a tornado. Interview on 3/13/25 with staff #1 revealed: -She conducted fire and disaster drills at the facility with the clients. -She thought all required drills were conducted. Interview on 3/14/25 with the Administrator revealed: -She explained to staff #1 how to conduct fire and disaster drills after she was last cited. -Staff #1 did not understand what she meant when she explained the fire and disaster drills. -She had "come up with a plan" as to when fire and disaster drills were to be conducted. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		

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V 736	Continued From page 11	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility and its grounds were not maintained in a clean, safe, and attractive manner. The findings are: Observation on 3/13/25 at approximately 12:00 pm of the Foyer area revealed: -A hole approximately 3" wide behind the entrance door of the facility. -Two brown marks approximately 6" wide and 6" long behind the entrance door of the facility. Observation on 3/13/25 at 12:05 pm of the Den area revealed: -A non-working television located on the floor beside the sofa. -A black mark approximately 24" long located on a wall next to the sofa. Observation on 3/13/25 at 12:10 pm of Bedroom # 1 revealed: -A strong smell of urine. Observation on 3/13/25 at 12:15 pm under the Carport area revealed: -A full size mattress laid on top of a foldable table. Observation on 3/13/25 at 12:20 pm of the Backyard area revealed: -Wood ranging in sizes from 12 x 20, 14 x 20, 16 x 16, 20 x 20 piled on ground.	V 736	V736 Facility & Grounds Maintenance As of 3/25/25, all of the debris outside of the home under the carport has been removed. The facility administrator has a contractor who will repair, replace or paint areas inside the home identified as needing such. This includes the holes in the walls, marks on the walls and any other area in need of repair or replacement and will be completed by 4/15/25.	

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V 736	Continued From page 12 Interview on 3/13/25 with the Administrator revealed: -The mattress under the carport was taken out of a bedroom because it smelled of urine. -The mattress had been sitting outside under the carport since January 2025 and would be thrown away. -The wood located in the backyard was wood from the former deck and ramp. -The deck and ramp were being replaced, and construction had left the wood from the former deck and ramp in the backyard. -The pile of wood had been in the back yard for a few weeks. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		