DIVISION	or nearm service Re	guiation	· · · · · · · · · · · · · · · · · · ·		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		1818 000 024	B. WING		R
		MHL092-931			03/17/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
RRIGHTS	SIDE HOMES INC	4133 WHI	TE PINE DRI	VE	
District	IDE HOMED ME	RALEIGH	, NC 27612		
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V 000	INITIAL COMMENT	rs .	V 000		· · · · · · · · · · · · · · · · · · ·
	on March 17, 2025. This facility is licens category: 10A NCA	w-up survey was completed Deficiencies were cited. sed for the following service C 27G .5600A Supervised			
		sed for 6 and currently has a irvey sample consisted of		Brightside Raleigh	
V 105	27G .0201 (A) (1-7)	Governing Body Policies	V 105		
	POLICIES (a) The governing befacility or service showitten policies for to (1) delegation of material for admits (2) criteria for admits (3) criteria for disched) admission asses (A) who will perform (B) time frames for (5) client record material for the control of the contr	anagement authority for the alility and services; arge; arge; asments, including: a the assessment; and completing assessment. anagement, including: ared to document; ared to document; ared to document; ared to document; are		V105 Governing Body Polici As of 3/25/25 the facility administrator has complete application process to obtain a CLIA waiver.	
	ealth Service Regulation DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE

RECEIVED BY MHL & C 5/22/25

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Division (of Health Service Re	equiation			LAVOR DATE OF STREET
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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BRIGHTS	SIDE HOMES INC		NC 27612	•	
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	(M) the alternation	including referrale and			
		including referrals and			
	recommendations;	as and availible improvement	1		
		ce and quality improvement			
	activities, including	ji ud antikitine of a problity	1		
	(A) composition an	nd activities of a quality ality improvement committee;			
	assurance and que	assurance and quality			
	improvement plan;	authoring and avaluating the			
	(C) methods for m	onltoring and evaluating the			
	quality and approp	riateness of client care,	1		
		on of client outcomes and	1		
	utilization of servic	:es; ti-tt euremásico individina			
	(D) professional of	r clinical supervision, including	1		
	a requirement that	staff who are not qualified			
	professionals and	provide direct client services	1		
	shall be supervise	d by a qualified professional in	1		
	that area of servic	e;	1		
	(E) strategles for i	mproving client care;	1		
	(F) review of staff	qualifications and a			
	determination mad	de to grant			
	treatment/habilitat	ion privileges:			
	(G) review of all fa	italities of active clients who			
	were being served	in area-operated or contracted			
	residential program	ms at the time of death;			
	(H) adoption of sta	andards that assure operational			
	and programmatic	performance meeting	-		
	applicable standa	rds of practice. For this			
	purpose, "applical	ble standards of practice"	ļ		
	means a level of o	competence established with			
	reference to the p	revailing and accepted	ļ		
	methods, and the	degree of knowledge, skill and	-		
	care exercised by	other practitioners in the field:	1		
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Division of Health Service Regulation STATE FORM

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BRIGHT	SIDE HOMES INC		NC 27612		
	CUMMADV ČTA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	ON (X5)
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V 105	Continued From pa	age 2	V 105		
	Based on record refailed to develop an standards that ens programmatic perfectandards of practinstrument and Injugation (Clinical Laborator waiver. The finding Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver. Review on 3/13/25 revealed: -There was no doc CLIA waiver.	of the facility's records cumentation or evidence of a of client #1's record revealed: f 7/16/24. for Depressive Disorder; Acute A (Middle Cerebral Artery) ance Abuse; Antisynthetase Anxiety; Chronic Pain (back I knee); Chiarl Malformation S/P compression (1985); Chronic Lov Morbid Obesity.			
	Inject 0.75 ml sub	ght loss) - 1.7 milligrams (mg) - ocutaneously weekly.			
	-Admission date of -Diagnoses of Sc	5 of client #2's record revealed: of 8/30/24. hizophrenia - Unspecified; Hyperlipidemia; Sleep Apnea;			
		k Guide - Use to test blood sugs	ır	,,, F. b	
Division of STATE FO	Health Service Regulation	115	5899	417K11	If continuation sheet 3 of 13

STATEMEN	of Health Service Re	guiation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	MHL092-931			R 03/17/2025
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	ATE, ZIP CODE	
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BRIGHTS	IDE HOMES INC	RALEIGH	NC 27612		A
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V 105	Continued From pa	ige 3	V 105		
200000	once a week.				
	Administration Rec 2025 through Marc -Client #1's injection recorded weekly. Review on 3/13/25 Administration Rec 2025 through Marc -Client #2's blood of recorded once were Interview on 3/13/2 revealed:	25 with the Administrator			
	-She was aware the waiverShe was aware the sugar checksShe began the Classification of the confirmed the waiver.	nat she needed the CLIA nat client #2 received blood LIA waiver process but did not e facility failed to have a CLIA e blood sugar checks and		n a mana a na ana a na ana ana ana ana a	nt c
V 10	7 27G .0202 (A-E) I 10A NCAC 27G .0 REQUIREMENTS (a) All facilities sl description for the which: (1) specifies competency, work qualifications for (2) specifies the position:	nall have a written job o director and each staff position the minimum level of education k experience and other	1,	V107 Personnel Requireme The staff person has contact school she attended and re a copy of her diploma as of Going forward the administ ensure that any future appl proof of education prior to of employment.	ted the quested 3/25/25. trator will licants have

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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:		Personnel Registr	" y .	ļ		
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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:		applicants for em	ployment disclose any criminal	-		
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:		conviction. The in	mpace of this insortion of the			
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:		decision regarding	in relationship to the lob for	İ		
(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:		which the annlice	nt is applying.	}		
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:		/d) Staff of a faci	lity or a service shall be	- [
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:		currently licensed	, registered or certified in			
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:		accordance with	applicable state laws for the		22 mars	
(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:		services provided	1.	.		
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:		(a) A file shall be	maintained for each individual	· .		
verification of licensure, registration or certification. This Rule is not met as evidenced by:		employed indicat	ing the training, experience an	id	**************************************	
This Rule is not met as evidenced by:		other qualification	ns for the position, including	4		
This Rule is not met as evidenced by:		verification of lice	ensure, registration or			
Observan of Health Service Regulation		certification.				
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Observan of Health Service Regulation	1			***		
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Division of Health Service Regulation steet 5 of	1					
	Division of	f Health Service Regulati	ion	8299	A17K11	If continuation sheet 5 of

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STATE FORM

DIVISION O	of Health Service KE TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
			n sariaun		03/17/2025
		MHL092-931	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST		
DEMOUTS	SIDE HOMES INC		TE PINE DRIV I, NC 27612	E	
ВКІОЛІС				PROVIDER'S PLAN OF	CORRECTION (XS)
(X4) ID PREFIX TAG	/EXCHINEDIOIENC	ATEMENT OF DÉFICIENCIES Y MUST BE PRECÉDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
V 107	Continued From pa	eview and interviews, the	V 107		
	facility falled to cor affecting one of the findings are:	mplete personnel records ree audited staff (#1). The			
	staff #2 revealed: -Date of hire was	of the personnel record for 5/11/20.			
	-No educational ve				
	revealed: -She was respons -She previously he educationShe was not sure #1's education wa	is not in the personnel record. nat she did not have			
educationShe was not sure why documentation of client #1's education was not in the personnel recordShe confirmed that she did not have documentation of client #1's education. V 112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESMENT 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;		V 112	The QP has sent the guardian as of 3/10 Going forward if a attend the treatme QP will send the co	Treatment/Hab Plan ne document to the 8/25 for the signature. guardian is unable to ent update, then the completed update to gnature immediately	

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Division of Health Service Requisition STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
F CORRECTION	DENTIFICATION NUMBER.	A. BUILDING:		R
	MHL092-931	B. WING		03/17/2025
ROVIDER OR SUPPLIER				
IDE HOMES INC			/E	
	<u> </u>		PROVIDER'S PLAN C	F CORRECTION (X6)
/EARM MESICIENCY	/ MRIST BE PRECEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO DEFICIE	THE APPROPRIATE DATE
Continued From pa	ige 6	V 112		
annually in consultance responsible person (5) basis for evaluation outcome achievem (6) written consenters on sible party.	ation with the client or legally or both; ation or assessment of ent; and t or agreement by the client or or a written statement by the			
Based on record reacility failed to ha treatment plan with by the client or rest three clients (#2). Review on 3/13/26-Admission date control of the clients of Malachemic Left MC Stroke; Polysubst Syndrome (ASS); shoulder, bilatera (status post) Decontrol of the control of the control of the control of the guardian #1's treatment plan for th	eviews and interviews, the ve an annually updated h written consent or agreement sponsible party affecting one of The findings are: 5 of client #1's record revealed of 7/16/24. jor Depressive Disorder; Acute A (Middle Cerebral Artery) ance Abuse; Antisynthetase Anxiety; Chronic Pain (back I knee); Chiari Malformation S/ompression (1985); Chronic Lower Morbid Obesity. effective 7/29/24. signature or written consent or responsible party on client an.	P ww		
	This Rule is not in Based on record responsible party, provider stating who obtained. This Rule is not in Based on record responsible party, provider stating who obtained. This Rule is not in Based on record responsible party, provider stating who obtained. There was not a from the client or responsible party, provider stating who obtained. There was not a from the guardiar (status post) December 1910 per 1910	This Rule is not met as evidenced by: Based on record reviews and interviews, the 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 legolity and 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/ (status post) Decompression (1985); Chronic Lo Blood Pressure; Morbid Obesity. -Treatment plan effective 7/29/24. -There was not a signature or written consent	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 of responsible party, or a written stating why such consent or agreement by the client (#2). The findings are: Review on 3/13/25 of client #1's record revealed: -Admission date of 7/16/24Diagnoses of Major Depressive Disorder; Acute Ischemic Left MCA (Middle Cerebral Artery) Stroke; Polysubstance Abuse; Antisynthetase Syndrome (ASS); Anxiety, Chronic Palin (back shoulder, bilateral knee); Chiari Malformation S/P (status post) Decompression (1985); Chronic Low Blood Pressure; Morbid ObesityTreatment plan effective 7/29/24There was not a signature or written consent from the guardian or responsible party on client #1's treatment plan (1985); Chronic Low Blood Pressure; Morbid ObesityTreatment plan effective 7/29/24There was not a signature or written consent from the guardian or responsible party on client #1's treatment plan.	A BUILDING: MHL092-931 STREET ADDRESS, CITY, STATE, ZIP CODE

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
		MIN 003 024	B. WING		R 03/17/2025
		MHL092-931			
NAME OF F	PROVIDER OR SUPPLIER		RESS, CITY, STA		
OBJOLITS	SIDE HOMES INC		E PINE DRIVI		
BRIGHT			NC 27612	PROVIDER'S PLAN OF CORRECT	ON (X5)
(X4) ID PREFIX TAG	ノケスかい ひせだいけいどう	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TD BE COMPUEIR
V 112			V 112		
	written consent fro party on client #1's -She confirmed the written consent fro party on client #1's This deficiency co	ble for obtaining a signature or m the guardian or responsible treatment plan. at there was not a signature or m the guardian or responsible			
V 113	27G .0206 Client I 10A NCAC 27G .0 (a) A client record individual admitted contain, but need (1) an identification (A) name (last, find (B) client record in (C) date of birth; (D) race, gender (E) admission dat (F) discharge dat (2) documentation developmental didiagnosis coded (3) documentation assessment; (4) treatment/hab (5) emergency in shall include the number of the persudden illness or and telephone numbers of the persudden illness or and telephone numbers of the persudden illness or and telephone numbers of the persugnities persugnities persugnities persugnities persugnities and telephone numbers of the persugnities persugnities persugnities persugnities persugnities and telephone numbers of the persugnities persug	Records 206 CLIENT RECORDS shall be maintained for each d to the facility, which shall not be limited to: on face sheet which includes: st, middle, maiden); number; and marital status; te;	V 113	V113 Client Records As of 3/18/25 the consents Been forwarded to the guar signature. Going forward if has not returned the conser admission, then the adminition admit the client until the consents have been received.	dian for a guardian ots prior to strator will

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Division of Health Service Regulation		AND THE PERSON	CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		(X2) MULTIPLE CONSTRUCTION		COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		_
	1	MHL092-931	B. WING		R 03/17/2025
			SOFOE OITY OT	ATE 70 CODE	
NAME OF F	PROVIDER OR SUPPLIER		RESS, CITY, ST		
-	NAC HANGE INC		TE PINE DRIV	E	
BRIGHT	SIDE HOMES INC	RALEIGH,	NC 27612		A. () () () () () () () () () (
(X4) ID PREFIX TAG	/はなのは ひにだいばんご	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE
V 113	(7) documentation (8) documentation (9) if applicable: (A) documentation diagnosis accordin of Diseases (ICD-S (B) medication ord (C) orders and cor (D) documentation administration erro (b) Each facility sh relative to AIDS or	of services provided; of progress toward outcomes; of physical disorders of to International Classification O-CM);	V 113		
	Based on record of facility failed to make in the client record (#1). The findings Review on 3/13/2 -Admission date of Diagnoses of Make Ischemic Left MC Stroke; Polysubst Syndrome (ASS); shoulder, bilatera (status post) Dec Blood Pressure; In the documentation of the control of the contr	5 of client #1's record revealed: of 7/16/24. ajor Depressive Disorder; Acute A (Middle Cerebral Artery) tance Abuse; Antisynthetase Anxiety; Chronic Pain (back I knee); Chiari Malformation S/F ompression (1985); Chronic Lov	N		

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Division (of Health Service Re	egulation		AANOTA (ATION)	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
AND PLAN	OF CORRECTION	MHL092-931	B. WING		R 03/17/2025
		<u> </u>	DRESS, CITY, ST	ATE ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		TE PINE DRIV		
RRIGHTS	SIDE HOMES INC		, NC 27612		
Gittorre		****		PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX TAG	/MANU DESIGNO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE COMPLETE
V 113	Continued From pa	age 9	V 113		
V 114	revealed: -She did not "realizemergency care for #1's guardianShe was responsi signatureShe acknowledge emergency care for guardian.	te" that the permission to seek orm was not signed by client lible for obtaining the guardian's and that the permission to seek orm was not signed by the ency Plans and Supplies	V 114		
	10A NCAC 27G .0 AND SUPPLIES (a) Each facility shand a disaster plate these plans availate the county emerged request. The plane procedures and re(b) The plans shall and evacuation prosted in the facility. (c) Fire and disaster shall be held at least the peated for each Drills shall be consimulate the facility.	pall develop a written fire plan in and shall make a copy of tible ergency services agencies upon a shall include evacuation outes. If he made available to all staff rocedures and routes shall be a staff to a shall be a shift. Inducted under conditions that ity's response to fire shall have a first aid kit		V 114 Emergency Plans an As of 3/25/25 staff was reon procedures and protoco conducting fire & disaster (Each will be completed by residential staff on no less monthly basis and will be con all shifts within the qua. The administrator will ensurable been completed on a basis and will co-sign the foundation of the drill is completed	inserviced lis for drills. the than a completed rter. ure drills monthly

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Division of	<u>of Health Service Re</u>	equiation	AND LABOR TOTAL	CONSTRUCTION	(X3) DATE SURVEY
STATEMEN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DELAN OF CORRECTION (DENTIFICATION NUMBER:		` •		COMPLETED
AND PLAN	OF CORRECTION	IPARTALES LIPORALES AND ARRANGEMENT AT	A. BUILDING: _	A December 1	1 , 1
		MHL092-931	B. WING		R 03/17/2025
W.A		ν ταρατο	DRESS, CITY, ST	ATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		E PINE DRIV		
BRIGHTS	SIDE HOMES INC		NC 27612		
······································				PROVIDER'S PLAN OF CORRECT	ON (X5)
(X4) ID PREFIX TAG	/EACH DESIGIENC!	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 114	Continued From pa	age 10	V 114		
	Based on record re facility failed to ens	et as evidenced by: eview and Interviews, the sure disaster drills were done shift. The findings are:			
	from April 2024 - N -There were no dis the 2nd quarter (A -There were no dis	of the facility's disaster drill log March 2025 revealed: saster drills conducted during pril, May, June) of 2024. saster drills conducted during ctober, November, December)			
	of 2024. Interviews on 3/13 revealed: -Staff #1 conducte -Clients #1, #2, an escorted outside in the facility during a -Clients #1, #2, ar into the facility's hunterview on 3/13/-She conducted fi facility with the clieshe thought all revealed: -She explained to disaster drills afterwhen she explained to when she explained and disaster drills and disaster drills and disaster drills.	i/25 with clients #1, #2, and #3 ad fire and disaster drills. ad #3 reported that they were a fire drill. ad #3 reported that they went allway in the event of a tornado. 25 with staff #1 revealed: re and disaster drills at the			
	and must be corr	ected withIn 30 days.			
	i .		· · · · · · · · · · · · · · · · · · ·		

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
STATEMENT	r of deficiencies of correction	IDENTIFICATION NUMBER:	A, BUILDING:		COMPLETED
WIAS LENGT	NI Comit deservations			•	l R
		MHL092-931	B. WING		03/17/2025
		<u> </u>	DRESS, CITY, S	TATE ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		TE PINE DRI		
BRIGHTS	IDE HOMES INC		, NC 27612	• -	
			ID.	PROVIDER'S PLAN OF CO	DRRECTION (X6) NISHOULD BE COMPLETE
(X4) ID PREFIX TAG	/さんたい ひだらげいにいご	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETE E APPROPRIATE DATE
V 736	Continued From pa	age 11	V 736		
		lity and Grounds Maintenance	V 736	à	
5 100				•	
:	10A NCAC 27G .0 EXTERIOR REQL	303 LOCATION AND		V736 Facility & Ground	ls Maintenance
	EXTERIOR REGION OF	nd its grounds shall be	1	As of 3/25/25, all of th	
	maintained in a sa	_{ife,} clean, attractive and orderly	· \	debris outside of the h	1
	manner and shall	be kept free from offensive	-	carport has been remo	oved. The facility
	odar.		1	administrator has a co	
	This Didn is not n	net as evidenced by:		repair, replace or pain	t areas inside
	Resed on observa	ation and interview, the facility		the home identified as	needing such.
1	i and its grounds W	ere not maintained in a ciean,	1	inis includes the holes	in the walls,
	safe, and attractiv	e manner. The findings are:		marks on the walls and	any other area
		/13/25 at approximately 12:00		in need of repair or rep	lacement and
	pm of the Foyer a	rea revealed:		will be completed by 4,	/15/25.
	-A hole approxima	ately 3" wide behind the		AND ALL AND 1 1 to 1 to 1 1 to	
1	entrance door of	the facility.			
l	-Two brown mark	s approximately 6" wide and 6"			
	long behind the e	ntrance door of the facility.			
1	Observation on 3	/13/25 at 12:05 pm of the Den			
	area revealed:		***************************************		
1	-A non-working te	elevision located on the floor			
	beside the sofa.	proximately 24" long located or	n	***************************************	
1	a wall next to the	sofa.			
	""			***	
	Observation on 3	3/13/25 at 12:10 pm of Bedroom	3	Second Control of Cont	
1	#1 revealed: -A strong smell o	f urina			
	-A strong sineli d	n urate.			
1	Observation on 3	3/13/25 at 12:15 pm under the			
1	Carnort area rev	ealed:	۵		
1	-A full size mattro	ess laid on top of a foldable tabl	₩,		
	Observation on	3/13/25 at 12:20 pm of the			
	Rackvard area re	evealed:			
1	-Wood ranging in	n sizes from 12 x 20, 14 x 20, 1	6		
1	x 16, 20 x 20 pile	ed on ground.			

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Division o	of Health Service Re	equiation			(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		m 11/15/00		03/17/2025	
		MHL092-931	B, WING		1 23/11/4542
		STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 4133 WHITE PINE DRIVE					
BRIGHTSIDE HOMES INC RALEIGH, NC 27612					
		ATEMENT OF DEFICIENCIES	GI	PROVIDER'S PLAN OF CORRECT	10N (X6)
/EACH DESIGN		"V MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE	
TAG	'''				
V 736	6 Continued From page 12		V 736		
	Interview on 3/13/25 with the Administrator revealed: -The mattress under the carport was taken out of a bedroom because it smelled of urineThe 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.				
			***************************************		1
			1		
					1
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.				

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Division of	Health Service Regulati	on	6993	A17K11	If continuation sheet 13 of 1

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