STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-108	A. BUILDING: _____ B. WING _____	R-C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS AHEAD AT ROCKY MOUNT INC	1521 BEDFORD ROAD ROCKY MOUNT, NC 27801

(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 A follow up and complaint survey was completed on July 12, 2018. The complaint was substantiated Intake #NC00140311 & #NC00140318. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-108	A. BUILDING: _____ B. WING _____	R-C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS AHEAD AT ROCKY MOUNT INC	1521 BEDFORD ROAD ROCKY MOUNT, NC 27801

(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 291	Continued From page 1 or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate with other qualified professionals (QP) who are responsible for the treatment/habilitation for one of three audited clients (former client (FC#1). The findings are: A. Review on 7/10/18 of FC#1's record revealed: - admitted to the facility on 5/23/18 and discharged 6/4/18 - diagnoses of Severe Intellectual Disabilities; Conduct Disorder; Major Depressive Disorder and Alcohol Affecting Fetus; Adjustment Disorder and Malignant germ cell tumor of right ovary - no documentation on the facility's initial assessment about swollen feet Review on 7/10/18 of an incident report dated 6/12/18 revealed: "...[FC#1] reported to the Director that she had sex with another member. The Director asked both members to come to her office. She spoke with them both regarding [FC#1] allegations of consensual sex. Both members denied having sexual intercourse with each other...guardian was not contacted because [FC#1] member denied to having consensual sex with another member..." During interview on 7/11/18 the guardians of FC#1 reported: - they were not made aware of any sexual allegations while FC#1 was at the respite facility - FC#1 made her Alternative Family Living (AFL) caregiver aware of the sexual allegations after she left the respite facility	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-108	A. BUILDING: _____ B. WING _____	R-C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS AHEAD AT ROCKY MOUNT INC	1521 BEDFORD ROAD ROCKY MOUNT, NC 27801

(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 291	Continued From page 2 During interview on 7/12/18 the QP for the AFL facility in which FC#1 resides in reported: - she was not made aware of the sexual allegations until FC#1 returned to the AFL facility - she attempted to contact staff #1 and left a message (no return phone call) on one occasion - she attempted the Licensee on 2 occasions however, her voicemail was full and a message could not be left During interview on 7/12/18 the Licensee reported: - the guardians were not contacted because FC#1 denied the allegations - in the future guardians will be contacted about any allegations that could affect the welfare of a client B. During interview on 7/11/18 FC#1's caregiver reported: - when FC#1 return to the AFL facility from respite her feet and ankles were swollen - FC#1 had surgery in April 2018 and had a follow up with her oncologist - he was concerned her feet was swollen and medical attetion had not been sought During interview on 7/11/18 FC#1's guardian reported: - a visit was made to the respite facility to see FC#1 - they noticed her feet were swollen during the time of the visit - they requested FC#1 to monitored her diet....avoid a high sodium intake - they did not request she been seen medically During interview on 7/11/18 a nurse from FC#1's oncologist reported:	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-108	A. BUILDING: _____ B. WING _____	R-C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS AHEAD AT ROCKY MOUNT INC	1521 BEDFORD ROAD ROCKY MOUNT, NC 27801

(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 291	Continued From page 3 - FC#1 was seen on 6/20/18 - both her feet were swollen from her ankles to below - she had on flip flops during the visit - the physician tested for blood clots and the results were negative - they were unsure of why her feet were swollen - they physician did not have concerns about her care at this time During interview on 7/12/18 staff #1 reported: - she completed the assessment for FC#1 - she noticed swelling with FC#1's feet, however FC#1 told her "she just had big feet" - the guardians came to the respite facility and told FC#1 to watch her salt intake...said FC#1 liked chips - FC#1 did not complain of any pain during her stay at respite and she (staff #1) did not recommend medical attention During interview on 7/12/18 the Licensee reported: - she did not notice any swelling with FC#1's feet, however staff #1 made her aware of the swelling - medical attention was not sought - medical attention will be sought in the future for any medical concerns	V 291		