Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						R	
		MHL078-159		B. WING		10/15/2018	
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
A BETTE	R WAY RESIDENTIA	I SERVICES		INS ROAD N, NC 28386	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS		V 000			
	completed on Octo was unsubstantiate Deficiencies were of This facility is licens	sed for the following c	mplaint 550). ategory:				
	10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.						
V 114	4 27G .0207 Emergency Plans and Supplies			V 114			
	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. (d) Each facility shall have basic first aid supplies accessible for use.						
	Based on record re failed to ensure fire	et as evidenced by: eview and interview, the and disaster drills we ated on each shift. The	ere held				
	- No fire drills comp September 2018.	8 of facility records revoleted from June 2018 completed from June	3 thru				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
MHL078-159			B. WING			R 10/15/2018		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
A BETTE	A BETTER WAY RESIDENTIAL SERVICES 220 CALVINS ROAD SHANNON, NC 28386							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 114	Continued From pa	ge 1		V 114				
	thru September 20°	18.						
	Interview on 10/12/ Manager stated: - The facility had no drills from June 201 - She would ensure required.	ot completed disas 18 thru September	ster and fire 2018.					
	Interview on 10/15/ stated she was awa were required to be each shift.	are the disaster an	nd fire drills					
V 118	27G .0209 (C) Med	ication Requireme	ents	V 118				
	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shad clients only when a client's physician. (3) Medications, incliadministered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ac all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for	inistration: non-prescription died to a client on the uthorized by law to all be self-administ uthorized in writing cluding injections, by licensed person trained by a regis regally qualified person e and administer of liministration Reconed to each client of self administered shely after administration he following:	e written o prescribe tered by g by the shall be s, or by stered nurse, person and medications. rd (MAR) of must be kept all be ation. The					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL078-159)	B. WING			R 15/2018
	PROVIDER OR SUPPLIER ER WAY RESIDENTIAL	_ SERVICES	220 CALV	DRESS, CITY, S INS ROAD N, NC 28386	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa (D) date and time the (E) name or initials drug. (5) Client requests checks shall be received file followed up by a with a physician.	ne drug is adminis of person adminis for medication cha orded and kept w	stering the anges or ith the MAR	V 118			
	This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to administer medications as ordered by a physician and failed to keep MARs current affecting two of three audited clients (#2 and #4). The findings are: A. Review on 10/12/18 of client #2's record revealed: - 12 year old male Admission date of 02/09/18 Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Mood Disorder and Disruptive Mood Dysregulation.						
	Review on 10/12/18 medication orders of a linvega (anti-psychone tablet daily at bushesses - Benztropine (treat symptoms) 0.5mg - Loratadine (treats tablet daily Guanfacine (treats take one tablet three Review on 10/12/18	dated 10/03/18 revolution of the protection of t	vealed: (mg) - take ease type daily. take one sure) 1mg -				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. BOILDING.		R		
		MHL078-159	B. WING		10/1	5/2018
NAME OF PROVI	IDER OR SUPPLIER			STATE, ZIP CODE		
A BETTER W	AY RESIDENTIAL	SERVICES		3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
201 - In' - Be 09/ and - Lo 09/ - Gi 09/ 3pn Inte his B. F reve - 17 - Ac - Di and Rev ord med - Di tabl - Ol tabl - Ol - Ar cap - Hy cap - Tr	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118	DEPICIENCY)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL078-159		B. WING		R 10/15/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
A BETTE	R WAY RESIDENTIA	I SERVICES	INS ROAD N, NC 28386	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 4	V 118			
	- Divalproex - 08/13 - Olanzapine - 08/1 - Amantadine - 08/	3/18 at 7am.				
	7am and 09/25/18 at Olanzapine - 09/0 09/12/18 at 7am ar - Amantadine - 09/0 09/25/18 at 7am ar - Hydroxyzine - 09/25/18 and - Trazodone - 09/25/18 and - Trazodone - 09/25/18 is medications as Interview on 10/12/15/15/15/15/15/15/15/15/15/15/15/15/15/	14/18, 09/05/18, 09/09/18, and 09/25/18 at 7am and 7pm. 09/18, 09/12/18 at 7am and 7pm. 05/18, 09/12/18 at 7am and ond 7pm. 05/18, 09/09/18, 09/12/18 and 09/20/18 at 7pm. 5/18. 18 client #4 stated he received ordered. 18 the Assistant manager heir medications as ordered. rgotten to sign the MARs. 19 accurately document stration it could not be s received their medications				

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