

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL033-051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2019
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NAME OF PROVIDER OR SUPPLIER BETTER DAYS AHEAD INC #4	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SOUTH GLENDALE AVENUE ROCKY MOUNT, NC 27801
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(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	<p>INITIAL COMMENTS</p> <p>An Annual and Complaint Survey was completed 02/07/19. The complaint was unsubstantiated (Intake #00144446). No deficiencies cited.</p> <p>This facility is licensed for the following service category NCAC 27G.5600F Supervised Living/Alternative Family Living</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____