Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						R		
		MHL033-108		B. WING		02/1	2/2019	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BETTER DAYS AHEAD AT ROCKY MOUNT INC 1521 BEDFORD ROAD								
				IOUNT, NC	T			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 000	V 000 INITIAL COMMENTS			V 000				
		w up survey was coi 19. A deficiency was						
		sed for the following C 27G .5100 Comm						
V 272	27G .5101 Community Respite - Scope			V 272				
	27G .5101 Community Respite - Scope  10A NCAC 27G .5101 SCOPE  (a) Community respite is a service which provides periodic relief for a family or family substitute on a temporary basis. While overnight care is available, community respite services may be provided for periods of less than 24 hours on a day or evening basis. Respite care may be provided by the following models:  (1) Center-based respite - the individual is served at a designated facility. While an overnight capacity is generally a part of this service, a respite center may provide respite services to individuals for periods of less than 24 hours on a day or evening basis.  (2) Private home respite - the individual is served in the provider's home on an hourly or overnight basis.  (b) Private home respite services serving individuals are subject to licensure under G.S. 122C, Article 2 when:  (1) more than two individuals are served concurrently; or  (2) either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.							
	This Rule is not me Based on record re	et as evidenced by: view and interview th	ne facility					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

		A. BUILDING:		00	(X3) DATE SURVEY COMPLETED	
	MHL033-108	B. WING			R <b>12/2019</b>	
PROVIDER OR SUPPLIER		ET ADDRESS, CITY, S	STATE. ZIP CODE			
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DATS AREAD AT RU	ROC	KY MOUNT, NC	27801			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETE DATE	
Continued From pa	ge 1	V 272				
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-Admission date -Diagnoses of A	e of 8/9/18 Autism and Attention Defici					
months revealed cli Monday through Fri	ent #1 had stayed in the hoday of every week, he stay	ome				
Further review on 2/4/19 of client #1's record revealed a treatment plan dated 1/1/19 and a meeting held on 11/12/18 revealed:  -"At this time due to behavioral concerns, my family is researching other residential options. An application has been submitted to [psychiatric hospital] and I am on the wait list at this time. I am currently in Respite at [facility].		Án				
-Client #1 was in MCO for placement permanent place for the was living head of the could not handle his physically for her.  -He was only so weeks, and it has to the could placements, but not have the placements of the placements of the placements.  -No problems whim all day.  -He is not in sol	referred to them by the local until they can find a r him. nome with his mother, but an as he was too aggressive upposed to be there for a fourned into six months, he is on a wait list for other to sure when. With him, he has a staff with thool, staff takes him out into the sure when.	al she e ew				
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Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		MHL033-108		B. WING			R <b>12/2019</b>		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1521 BEDFORD ROAD ROCKY MOUNT, NC 27801								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 272	During interview on of client #1 stated:     -They placed cl could find him a per placed could find him a per placed. They placed could find him a per placed in the place	2/7/19 the Care Coordient #1 in Respite untropendent. It would take this longue him in a licensed AFL) home, but they are not on an AFL that is inney will place him in another did not want to ender respite home because in a permanent home. It to enroll in a new school to enroll	il they  J. Iternative e all full. n the ny day. nroll him use of his ol and nool ent only e to  ient #1 few ocated. while telling	V 272	DEFICIENC	Y)			

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