

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL033032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/07/2019
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NAME OF PROVIDER OR SUPPLIER BETTER DAYS AHEAD OF ROCKY MOUNT, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1713 KINGS CIRCLE DRIVE 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
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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 2/7/19. A deficiency was cited. The facility is licensed for the following service category 10A NCAC .27G 5600C Supervised Living for Developmentally Disabled Adult.	V 000	<p style="text-align: center;">DHSR - Mental Health</p> <p style="text-align: center;">APR 30 2019</p> <p style="text-align: center;">Lic. & Cert. Section</p> <p>Effective 3/1/19 the following repairs were made to the facility; cable wire was removed from laying across the client floor and safely secure, base-board in client room was replaced , metal plate in client bath tub was replaced, coffee table was taken out and the carpet was taken up and replaced with linoleum. Better Days Ahead Of Rocky Mount qualified Professional will complete quarterly In- home inspection, if any findings are noted a work order sheet will be filled out and all repairs will be completed with in 30 days for the inspection. The Qualified Professional will follow up after the 30 days to ensure that all repairs are completed and are in compliant according to the Division Of Health Services Regulations</p>	
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure the home was maintained in a safe, attractive manner. The findings are:</p> <p>Observation on 2/7/19 at 2:00 PM revealed the following: <ul style="list-style-type: none"> -Client bedroom had a cable wire laying across floor where it had been ripped off the wall. -Baseboard in client bedroom was rotted and wood falling off. -Baseboard in client bathroom was rotted and wood coming apart. -Metal plate in client bath tub was rusted and had sharp edges. -Coffee table in common area had legs broken and barely standing up. -Carpet down stairs was ripped and rippled throughout the room. </p>	V 736		

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

E2G311

If continuation sheet 1 of 2

Mary G. Baulieu

Director of Administration 4/25/19

Division of Health Service Regulation

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V 736	<p>Continued From page 1</p> <p>During interview on the Qualified Professional (QP) stated: -Had not been in the home in a while to check on things. -"Its my fault, I take full responsibility for not checking in to make sure repairs are completed."</p> <p>During interview on 2/7/19 the Licensee stated: -Had a repair guy to come out to the homes to repair things. -Had not followed up to make sure he completed requested repairs. -Need to make sure all repairs are completed as requested before payment rendered.</p>	V 736	<p>Effective 3/1/19 the following repairs were made to the facility; cable wire was removed from laying across the client floor and safely secure, baseboard in client room was replaced , metal plate in client bath tub was replaced, coffee table was taken out and the carpet was taken up and replaced with linoleum. Better Days Ahead Of Rocky Mount qualified Professional will complete quarterly In-home inspection, if any findings are noted a work order sheet will be filled out and all repairs will be completed with in 30 days for the inspection. The Qualified Professional will follow up after the 30 days to ensure that all repairs are completed and are in compliant according to the Division Of Health Services Regulations</p>	
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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

February 13, 2019

Mr. Kelvin Barnhill/ Keith Barnhill
Better Days Ahead, Inc.
P.O. Box 909
Rocky Mount, NC 27802

Re: Annual and Follow Up Survey completed 2/7/19
Better Days Ahead of Rocky Mount, Inc., 1713 Kings Circle Drive, Rocky Mount, NC
MHL # 033-032
E-mail Address: barnhillceoperation2001@aol.com

DHSR - Mental Health
APR 30 2019
Lic. & Cert. Section

Dear Mr. Barnhill:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 2/7/19.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Tag cited is a standard level deficiency.

Time Frames for Compliance

- Standard level deficiency must be corrected within 60 days from the exit of the survey, which is 4/7/19.

What to include in the Plan of Correction

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski-Ames at 919-552-6847.

Sincerely,



Kimberly Thigpen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section



Keisha N. Douglas
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
DHSRreports@eastpointe.net
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
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