Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
					R			
		MHL064-145	B. WING		02/04/2020			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BETTER DAYS AHEAD GROUP HOME #6 501 CASCADE AVENUE ROCKY MOUNT, NC 27803								
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	An Annual and Follow on 02/04/20. Deficien	Up Survey was completed ucies were cited.						
	category: 10A NCAC	I for the following service 27G .5600C Supervised Developmental Disability.						
V 512	27D .0304 Client Righ	nts - Harm, Abuse, Neglect	V 512					
	(a) Employees shall pabuse, neglect and exwith G.S. 122C-66. (b) Employees shall resort of abuse or negle 27C.0102 of this Chack (c) Goods or services purchased from a clie established governing (d) Employees shall unecessary to repel or aggressive client and governing body policy is necessary depends characteristics of the and physical and men of aggressiveness disintervention procedure Subchapter 10A NCA (e) Any violation by a	crotect clients from harm, exploitation in accordance and subject a client to any ect, as defined in 10 A NCAC apter.  Is shall not be sold to or an except through a body policy.  Is eas only that degree of force secure a violent and which is permitted by a compliance that is upon the individual client (such as age, size antal health) and the degree applayed by the client. Use of es shall be compliance with C 27E of this Chapter.  In employee of Paragraphs Rule shall be grounds for						
		ew and interview one of one ree of three clients (#1-#3)						

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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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		A. BUILDING: _					
		MHL064-145	B. WING		R 02/04/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BETTER DAYS AHEAD GROUP HOME #6 501 CASCADE AVENUE							
BETTER	DATS AREAD GROUP RO	ROCKY I	OUNT, NC 278	03			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE		
V 512	Continued From page	e 1	V 512				
	Review on 01/30/20 o -Hire date of 06/	of staff #1's record revealed: 10/15					
	Review on 01/30/20 or revealed: -Admitted: 01/25						
		Intellectual Disability, ertension, Insomnia and					
	Review on 01/30/20 or revealed:	of client #2's record					
	-Admitted: 2016 -Diagnoses: Mild Intellectual Disability and Impulsive Disorder  Review on 01/30/20 of client #3's record revealed: -Admitted: 01/15/15 -Diagnoses: Mild Intellectual Disability and Schizophrenia						
	-He had concern	1/30/20, client #3 reported: s with the way staff #1					
	_	#1 and just causes a big scene. g to herShe yells at him to					
	-"I don't think she	e likes me. She don't talk to ce to everyone but me and e her alone."					
	-He was ready to at the group home. -Staff #1 yelled a him. He did not like to	1/30/20, client #1 reported: be out on his own and not it him when she talked to be yelled at. She yelled for whatever she asked him to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL064-145	B. WING	·	02	R 2 <b>/04/2020</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E. ZIP CODE	•		
			CADE AVENUE	,			
BETTER	DAYS AHEAD GROUP H	IOME #6 ROCKY	MOUNT, NC 27803	3			
(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 APPROPRIATI DEFICIENCY)		(X5) COMPLETE DATE	
V 512	-A few weeks as "jump on mehit me -"He (client #2) him to."  During interviews be 01/31/20, client #2 reat client #1 like sh -"If I did not war #1] would allow me If [client #1] asked ha bath that night." -Staff #1 yelled Staff #1 "did not yell -Staff #1 told him did not touch him. It sure why she asked he went to his room  During interview on -Client #1 was to the group home. He tasks. He did not like a little "frustrated", so was a client and requipell at him when she she would new another client. She would new another client. She would think otherwise During interviews be Administrator report -Prior to this interviews deconcerning group home treated -Client #1 requipents as he did not to the sinterviews as he did not the client #1 requipents a	go, staff #1 told client #2 to e."  hit me because [staff #1] told  etween 01/30/20 and eported: d him okay but she did not he treated everyone else. In to take a bath at night, [staff to take a bath in the morning. er, she would make him take  when she talked to client #1. At me. She talks to me nice." In to "beat up [client #1] but I walked away." He was not him to "go get" client #1 but instead.  01/31/20, staff #1 reported: he most challenging client at required directives on all to take baths. When she got he reminded herself that he uired assistance. She did not to spoke to him er instruct one client to hit was not sure why anyone ise.	V 512				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _		35 22.25	
MIII 004 445		B. WING		R	
	MHL064-145	5		02/04/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BETTER DAYS AHEAD GROUP HOM	501 CASC	ADE AVENUE			
	ROCKY MO	OUNT, NC 278	03		
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 512 Continued From page 3	<b>,</b>	V 512			
dinner. Client #1 requires some physical assistance. Over the weekend internal investigation and versions from the clients informed her of concerns Staff #1 talked loud in not tone at times.  During the internal now reported staff #1 did hit client #1. Staff #1 as #1. He described "go go obtain client #1 for her to talk because she had so #2 liked to "boss around interviewed staff #1 as to have provided her difference. She would submit Carolina Health Care Peadhere to the processes.  Review on 02/03/20 of to Protection dated 02/03/20. Administrator revealed:  "What will you immadove rule violations in from further risk or addit Ahead Of Rocky Mount due to further investigat trained on using better of involve any member to encompetencies to ensure understanding of the election competencies to ensure understanding of the election competencies to ensure the professional and the Direction and members of the professional and the Direction and the Direct	ed verbal prompts and ce with hygiene. It, she conducted an aid obtained 4 different is. None of the clients is staff #1 yelled at them. ature and used a sharp.  If investigation, client #2 id not ask him to beat or ked him to "go get" client et" as in to physically go because staff #1 could not bome dental work. Client d" client #1. She had not the clients seemed to rent information. Ther findings to the North ersonnel Registry and is outlined by that entity.  The facility's Plan of 20 submitted by the mediately do to correct the order to protect clients tional harm? Better Days Inc. has removed staff cions. All staff will be choice of words and not to do their job. Inside the stage of the protect clients at the above reained on all CAP is the protect of the protect of Interaction, embers Rights. Qualified	V 512			

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				(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		MHL064-145	B. WING		02	R / <b>04/2020</b>
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BETTER D	AYS AHEAD GROUP H	OME #6	SCADE AVENUE / MOUNT, NC 27803	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From page 4  Clients #1-#3 in the group home had primary diagnosis of Mild Intellectual Disability. Staff #1 told client #2 to beat up client #1. All three clients expressed concerns of how staff #1 yelled when she interacted with client #1. This type of staff behavior was detrimental to the welfare of the clients. The violation constitutes a Type B rule violation and must be corrected within 45 days. If the violation is not corrected within 45 days, an additional administrative penalty of \$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.		V 512			
V 736	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and i maintained in a safe,	EMENTS	V 736			
	failed was not mainta finding is:  Observation and tour 12:30 PM revealed:  -Mattresses work by two of three client -The mattresses metal spring could be slept on it	n and interview, the facility lined in a safe manner. The of the facility on 01/30/20 at in two bedrooms occupied				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		MHL064-145	B. WING		I	R / <b>04/2020</b>		
NAME OF P	ROVIDER OR SUPPLIER			TE ZIP CODE	02	104/2020		
	501 CASCADE AVENUE							
BEITERL	DAYS AHEAD GROUP HO	ROCKY N	OUNT, NC 278	03				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
V 736	Continued From page	e 5	V 736					
	reported: -She had not noticed the mattress prior to the tour.							
		1/30/20, client #3 reported: d been worn for a while ion it to staff						
	During interview on 02/03/20, the Administrator reported:  -She would have the mattresses at the group home replaced							
	This deficiency const and must be correcte	itutes a re-cited deficiency d within 30 days.						

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