| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | MHL078-159 | B. WING | | | ⋜ 02/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREE | T ADDRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | ER WAY RESIDENTIAL | SERVICES | ALVINS ROAD NON, NC 28386 | 3 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENT | rs | V 000 | | | |
| | completed on June unsubstantiated (in Deficiencies were continuous facility is licensed) | sed for the following service C 27G .1700 Residential | S | | | |
| V 105 | 27G .0201 (A) (1-7) |) Governing Body Policies | V 105 | | | |
| | POLICIES (a) The governing to facility or service show written policies for to the face of the face o | anagement authority for the cility and services; ssion; sarge; ssments, including: an the assessment; and completing assessment. Inagement, including: zed to document; cords; cords against loss, tamperic by unauthorized persons; cord accessibility to all times; and onfidentiality of records. | ng, g | | | |

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

(X6) DATE TITLE

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | MHL078-159 | B. WING | | 06/0 | 2/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | INS ROAD | • | | |
| | OUR MARK OTA | | N, NC 28386 | | O.U. | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 105 | Continued From pa | ge 1 | V 105 | | | |
| V 103 | recommendations; (7) quality assurance activities, including: (A) composition and assurance and quality at improvement plan; (C) methods for more quality and approprincluding delineation utilization of services (D) professional or a requirement that professionals and professionals | ce and quality improvement d activities of a quality lity improvement committee; ssurance and quality onitoring and evaluating the iateness of client care, n of client outcomes and es; clinical supervision, including staff who are not qualified provide direct client services by a qualified professional in ; nproving client care; ualifications and a e to grant | V 103 | | | |

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Division of Health Service Regulation STATE FORM

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL078-1 | 59 | B. WING | | 06/0 | ₹ 02/2021 |
| | | WITTEO7 0-1 | | | | 1 00/0 | 1212021 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | | 'INS ROAD N, NC 28386 | 3 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO | D BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| V 105 | Continued From pa | ge 2 | | V 105 | | | |
| | This Rule is not me Based on record re interviews, the facil standards that assu practice amidst the (Coronavirus-Disea findings are: | views, observati ity failed to imple ire applicable sta COVID-19 se-2019) pande | on and ement written andards of mic. The | | | | |
| | Review on 6/1/21 of the facility's COVID-19 posted undated policy and procedure revealed: -"Provided respiratory hygiene supplies (e.g., hand hygiene agents, tissues, face masks, trash receptacle) throughout the facility for use by residents, staff, and visitors." | | | | | | |
| | Review on 6/2/21 S Executive Order No Restrictions to Reflexecommendations -"Section 2. Face Of Coverings are also Section 3 of this Ex 3. Restriction on Co Operations3.3 He Prevention in Healt workers, and visitor including hospitals, Long Term Care ("L facilities ("SNF"), ar for individual with in ("ICFIID"), must foll CDC (Centers for D Prevention) Health Control Recomment COVID-19 Vaccinar | o. 215 Lifting CO ect New Public F dated 5/14/21 resoveringsIn addrequired in the secutive Order been alth Care Setting to Care Facilities in health care outpatient health TC") Facilities, so the lift ow the requirem Disease Control actions in Respondations in Responder to Care Infection and adations in Responder to Care Infection and care Infection and care Infection in Responder to Care Infection and Car | VID-19 Health Evealed: dition, Face Letting listed in ElowSection Is and It residents, It residen | | | | |
| | Review on 6/2/21 o Department of Hea May 6th Webinar fr | lth and Human S | Services LTC | | | | |

Division of Health Service Regulation

STATE FORM 6899 4L0Q11 If continuation sheet 3 of 32

| MHL078-159 B. WING R 06/02/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 CALVINS ROAD | R | DING: | (X2) MUL A. BUILD | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | NT OF DEFICIENCIES N OF CORRECTION | |
|--|--|----------|----------------------|--|---|-----------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 CAI VINS ROAD | 06/02/2024 | 3 | B. WING | MHI 078-159 | | |
| 220 CALVINS ROAD | 00/02/2021 | | | WITIE078-133 | | |
| 220 CALVINS ROAD | | | | | PROVIDER OR SUPPLIER | NAME OF I |
| A BETTER WAY RESIDENTIAL SERVICES SHANNON, NC 28386 | | | | SERVICES | ER WAY RESIDENTIAL | A BETTE |
| | RRECTIVE ACTION SHOULD BE COMPLÉTE ERENCED TO THE APPROPRIATE DATE | IX (EACH | PREFI | JUST BE PRECEDED BY FULL | (EACH DEFICIENCY | PREFIX |
| providers revealed: -On pages 2-4 Personal Protection Equipment (PPE) Questions/Social DistancingQuestion #17: "Universal PPE should still be worn by staff when doing resident care activities- essentially any time staff is with residents. If all residents are vaccinated, the residents do not need masks or to be 6 feet apart, but the staff still need to wear face masks." Observation while in the facility on 6/1/21 from approximately 9:00am to 1:00pm, no staff or client had worn a face mask during the onsite visit. Interview on 6/1/21 staff #1 stated: -Staff complete temperature checks when clients and staff enter and leave the facilityStaff wore a mask when outside the facility with clients. Interview on 6/2/21 staff #2 stated: -Staff were not required to wear mask but she chose to wear a mask at the facility. Interview on 6/2/21 staff #3 stated: -It was not required for staff to wear mask in the facility. Interview on 6/2/21 the House Manager stated: -It was optional for staff to wear mask in the facility. Interview on 6/2/21 the House Manager stated: -It was optional for staff to wear mask in the facilityMask were required when clients and staff left the facilityNo clients had been vaccinated against COVID-19She had not been sure of any staff vaccination status. This deficiency constitutes a re-cited deficiency | | | | anal Protection Equipment cial Distancing. ersal PPE should still be oing resident care activities-staff is with residents. If all ated, the residents do not 6 feet apart, but the staff still asks." the facility on 6/1/21 from m to 1:00pm, no staff or e mask during the onsite taff #1 stated: erature checks when clients ave the facility. Then outside the facility with taff #2 stated: ed to wear mask but she k at the facility. taff #3 stated: or staff to wear mask in the the House Manager stated: aff to wear mask in the when clients and staff left vaccinated against ure of any staff vaccination | providers revealed: -On pages 2-4 Pers (PPE) Questions/Si -Question #17: "Un worn by staff when essentially any time residents are vaccin need masks or to b need to wear face r Observation while i approximately 9:00 client had worn a fa visit. Interview on 6/1/21 -Staff complete tem and staff enter and -Staff wore a mask clients. Interview on 6/2/21 -Staff were not requ chose to wear a ma Interview on 6/2/21 -It was not required facility. Interview on 6/2/21 -It was optional for facilityMask were require the facilityNo clients had bee COVID-19She had not been status. | V 105 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL078-159 | | B. WING | | | R 02/2021 |
| | PROVIDER OR SUPPLIER | . SERVICES | 220 CALV | DRESS, CITY, S INS ROAD N, NC 28386 | STATE, ZIP CODE | | |
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| V 105 | Continued From pa | | | V 105 | | | |
| V 118 | 27G .0209 (C) Med | • | 9 | V 118 | | | |
| | 10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when ar client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for (D) date and time th (E) name or initials drug. (5) Client requests checks shall be rec | inistration: non-prescription drug d to a client on the v uthorized by law to p all be self-administer uthorized in writing b cluding injections, sha y licensed persons, trained by a register legally qualified perse e and administer me ministration Record red to each client mu s administered shall ely after administratio | gs shall written rescribe ed by y the all be or by red nurse, son and edications. (MAR) of ist be kept be on. The drug; leg; red; and ring the ges or the MAR | | | | |

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Division of Health Service Regulation STATE FORM

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SFRVICES | 'INS ROAD N, NC 28386 | • | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF CORRECT | ION | (X5) |
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| V 118 | Continued From pa | ige 5 | V 118 | | | |
| | facility failed to admordered by a physic current affecting the #3) and one of four demonstrate compadministration. The Finding #1 Review on 06/01/2 revealed: -11 year old maleAdmission date of -Diagnoses of Depi Attention Deficit Hy Unspecified Anxiety | eviews and interviews, the ininister medications as cian and failed to keep MARs ree of three clients (#1, #2 and audited staff (#1) failed to etency with medication in findings are: 1 of client #1's record 02/05/21. ressive Mood Disorder, peractivity Disorder (ADHD), y Disorder, Oppositional DDD) and Post Traumatic | | | | |
| | physician orders re 2/5/21 -Divalproex (treats take 3 tablets at b-Aripiprazole (anti-pbedtime. | seizures) 250 milligrams (mg) | | | | |
| | bedtimeZyrtec (Cetirizine-t daily. Review on 6/1/21 a | es (sleep aid) 5mg - one at reats allergies) 10mg - once and 6/2/21 of client #1's March 1 MARs revealed the following | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | INS ROAD N, NC 28386 | ; | | |
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| V 118 | Continued From pa | ge 6 | V 118 | | | |
| | April 2021 -Divalproex - 4/15/2 -Concerta - 4/4/21, -Aripiprazole - 4/30, May 2021 -Divalproex - 5/1/21 5/31/21Aripiprazole - 5/1/2 5/31/21Melatonin - 5/1/21, thru 5/31/21Zyrtec - 5/1/21 thru | /21 thru 3/31/21. 3/3/21 and 3/25/21. 21, 4/22/21 and 4/30/21. 4/29/21 and 4/30/21. | | | | |
| | Interview on 6/1/21 his medications dai | client #1 stated he received ly as ordered. | | | | |
| | Finding #2: Review on 6/1/21 of client #2's record revealed: -14 year old maleAdmission date of 2/23/21Diagnoses of ADHD and Intermittent Explosive Disorder. | | | | | |
| | physician orders re 5/6/21 -Lithium Carbonate one at bedtime. | nd 6/2/21 of client #2's signed vealed: (treats Bipolar) 150mg - take eats seizure disorders) 15mg | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | |
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| V 118 | Continued From pa | ge 7 | V 118 | | | |
| | tablet dailyDocusate Sodium one tablet at bedtim -Sertraline (anti der dailyVitamin D2 (treats take one capsule to Review on 6/1/21 a 2021 thru May 2021 blanks: March 2021 -Quetiapine - 3/19/2-Docusate Sodium 3/29/21 thru 3/31/2 | vitamin deficiency) 1.25mg - vice a week. nd 6/3/21 of client #2's March 1 revealed the following 21 and 3/29/21 thru 3/31/21 3/18/21 thru 3/23/21 and 1. 3/3/21 and 3/31/21. | | | | |
| | April 2021 -Quetiapine - 4/1/21 4/5/21, 4/6/21 and 4/30/21Docusate Sodium - 4/1/21 thru 4/30/21Sertraline - 4/4/21 and 4/30/21Vitamin D2 - 4/1/21 thru 4/30/21. | | | | | |
| | 5/29/21 thru 5/31/2 -Docusate Sodium -Quetiapine - 5/1/2 5/31/21Oxcarbazepine - 5 thru 5/31/21Sertraline - 5/1/21 5/31/21Vitamin D2 - 5/1/2 | - 5/1/21 thru 5/31/21 1 thru 5/8/21 and 5/29/21 thru /1/21 thru 5/9/21 and 5/29/21 thru 5/7/21 and 5/29/21 thru 1 thru 5/31/21. client #2 stated he received | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/ IDENTIFICA | /SUPPLIER/CLIA TION NUMBER: | , , | E CONSTRUCTION | | SURVEY PLETED |
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| V 118 | Continued From pa | ige 8 | | V 118 | | | |
| | Finding #3 Review on 6/1/21 of -13 year old maleAdmission date of -Diagnoses of ODE and ADHD. | 9/2/20.), Conduct Dis | order, PTSD | | | | |
| | Review on 6/1/21 and 6/2/21 of physician orders for client #3 revealed: 9/17/20 -Divalproex 250mg, 1 tablet every morning (treat psychiatric conditions)Guanfacine 4mg, 1 tablet every night at bedtime (treat ADHD). | | | | | | |
| | 9/25/20 -Methylphenidate 3 morning (treat ADH | | ıle every | | | | |
| | 3/22/21 -Melatonin 3mg, 1 | tablet at bedtin | ne. | | | | |
| | Review on 6/1/21 of 11, 2021 to May 20 blanks: March 2021 -Divalproex - 3/25/ -Guanfacine - 3/29/ -MethylphenidateMelatonin - 3/29/2 | 21 revealed th 21. /21. 3/25/21. | | | | | |
| | April 2021 -Divalproex - 4/4/2 -Guanfacine - 4/10, -MethylphenidateMelatonin - 4/15/2 | /21. 4/4/21, 4/29/2 | 1, 4/30/21. | | | | |
| | May 2021 -Divalproex - 5/1/2 | 1 thru 5/5/21, 5 | 5/12/21, 5/29/21 | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUI IDENTIFICATION | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
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| (X4) ID | SUMMARY STA | TEMENT OF DEFICIE | | ID | PROVIDER'S PLAN OF CO | RRECTION | (X5) |
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| V 118 | Continued From pa | ge 9 | | V 118 | | | |
| V 118 | Continued From parthru 5/31/21Guanfacine - 5/1/25/31/21Methylphenidate - thru 5/31/21Melatonin - 5/1/21, 5/29/21 thru 5/31/22. Interview on 6/1/21 his medications dai Finding #4 Review on 6/2/21 or -Original hire date 9-Most recent rehire -Medication adminis 10/20/19"Coaching Docume 4/5/20 for Immediat Medication Error, N Protocol, not informe administered the will was also informed the will was also informed the error you then administered the will was a medication to the clicient having been gwhich was a medication formed them of will client informed them of will concerning your peron the job which was Comments: Recomments: Recomments: Recomments. | 1, 5/2/21, 5/29/2 5/1/21 thru 5/5/2 5/2/21, 5/4/21, 5 1. client #3 stated I ly. f staff #1's record 0/10/19. date 5/11/21. stration training of the Termination. "Cot following med ating staff and ma d that on 3/12/20 rong medication in that after you disc inistered the corr ient which resulting to the corr ient which resulting that after you disc inistered the corr ient which resulting that had occurred that had occurred that you then to the have been of the have been of the previously add | 1, 5/29/21 5/6/21, 5/7/21, he received d revealed: completed #1 dated Doccurrence. ication nagement of 1/20 you to a client. I covered the ect ed in the ect ed in the edication was also rou did not I and that the old the him other issues as sleeping resses. Staff | V 118 | | | |
| | administered the wi indicate that you we administration proto inform managemen | ere not following pocol. Because yout or the incoming | medication u did not g shift of what | | | | |
| | had occurred and to | old the client not | to tell anyone, | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | MHL078-159 | B. WING | | | 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIA | SERVICES | 'INS ROAD N, NC 28386 | 3 | | |
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| V 118 | it appears that you which could have refor this occurrence immediately." Signe Director/Licensee of Interview on 6/1/21 -He had administer -There was always clientsClients received the Interview on 6/1/21 Manager stated: -Clients had received -There was an error month ending on the -Staff used the medinitialized it to show administeredStaff #1 had not adhe was rehiredStaff #1 had not be administration since -Staff #1 was unable administration train had another job. Due to the failure to medication administration administration administration determined if client as ordered by the part of the staff was unable administration administra | were trying to hide the error esulted in harm to the client. You are terminated end by staff #1 and on 4/6/20. staff #1 stated: eed medications. enough medications for eir medication daily. and 6/2/21 the House end their medications daily. It is a medication count sheet and or medications were edministered medications since energy ene | V 118 | | | |
| V 121 | within 30 days. 27G .0209 (F) Med | ication Requirements | V 121 | | | |

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| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/IDENTIFICATION | SUPPLIER/CLIA TION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COME | SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | ER WAY RESIDENTIA | L SERVICES | | INS ROAD N, NC 28386 | | | |
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| V 121 | Continued From part 10A NCAC 27G .02 REQUIREMENTS (f) Medication review (1) If the client received governing body or for obtaining a review regimen at least eview shall be to be perfue physician. The onsthe client's physiciathe review when m (2) The findings of be recorded in the corrective action, if | ew: eives psychotro operator shall ew of each clie ery six months ormed by a pha site manager s an is informed edical interven the drug regim client record a | opic drugs, the be responsible ent's drug s. The review armacist or shall assure that of the results of tion is indicated. | V 121 | | | |
| | This Rule is not m Based on record re facility failed to ens clients (#3) had a p review at least ever are: Review on 6/1/21 c -13 year old maleAdmission date of -Diagnoses of Opp | eview and interure one of three one of client #3's re 9/2/20. ositional Defia | views, the ee audited rug regimen The findings cord revealed: nt Disorder, | | | | |
| | Conduct Disorder, Disorder and Atten Disorder (ADHD)No current drug re Review on 06/01/2 regimen revealed: -Divalproex DR 250 (treat psychiatric col- Guanfacine ER 4n | tion Deficit Hypegimen review. 1 of client #3's Dmg, 1 tablet eponditions). | current drug | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPL IDENTIFICATION N | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | | , , | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | | /INS ROAD N, NC 28386 | i | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 121 | Continued From pa | ge 12 | | V 121 | | | |
| | bedtime (treat ADH -Methylphenidate 3 morning (treat ADH -Melatonin 3mg, 1 t Interview on 6/2/21 -No psychotropic re #3. | Omg ER, 1 capsule D). cablet at bedtime (sl | eep aid). r stated: | | | | |
| V 295 | 27G .1703 Residen P | itial Tx. Child/Adol - | Req. for A | V 295 | | | |
| | day-to-day operatio (2) supervision regarding responsible implementation of extreatment plan; and | ressionals the qualified profession of this Section, to least one full-time exceeds the require sional as set forth in the responsible for and implement with the responsibilities anal(s). At a minimula set the following: the following: the facility; on of paraprofession of the day to detail the each child or adoles | each direct care ements of n 10A r each itten of its im these ay nals cent's | | | | |
| | This Rule is not me | et as evidenced by: | | | | | |

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Division of Health Service Regulation STATE FORM

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPP IDENTIFICATION I | | , , | E CONSTRUCTION | | E SURVEY PLETED |
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| | | MHL078-159 | | B. WING | | | R 02/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | | 'INS ROAD N, NC 28386 | ; | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENC MUST BE PRECEDED I SC IDENTIFYING INFOR | CIES BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| V 295 | Continued From pa | ge 13 | | V 295 | | | |
| | Based on record re failed to have at lea staff who meets or an Associate Profes | st one full-time directions one contraction in the state of the requirect of the state of the st | ect care ements of | | | | |
| | Review on 6/1/21 or revealed no AP liste | | nsus | | | | |
| | Interview on 6/1/21 Manager stated: -The facility did not -The position had b monthsThe Licensee adve it had not been filled | have an AP. een vacant for a coertised for the AP p | ouple osition, but | | | | |
| | Interview on 6/2/21 -She was in the pro the AP positionShe had advertised not been filledShe had a difficult | cess of seeking ap | oplicants for | | | | |
| V 367 | 27G .0604 Incident 10A NCAC 27G .06 REPORTING REQUITED A AND (a) Category A and level II incidents, existe provision of billate consumer is on the incidents and level to whom the provide 90 days prior to the responsible for the services are provided becoming aware of be submitted on a first service. | UIREMENTS FOR B PROVIDERS B providers shall a copt deaths, that cable services or what providers premise II deaths involving er rendered any se incident to the LM catchment area wheel within 72 hours the incident. The | report all occur during the the sor level III the clients ervice within Enere of report shall | V 367 | | | |

| DIVIDION | Of Fleatur Service IN | guiation | | | | | |
|--------------|-------------------------|------------------------------|-----------------|--------------|--|-----------|----------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUF | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION | N NUMBER: | A. BUILDING: | | COMP | LETED |
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| | | MHL078-15 | 9 | D. WING | | 06/0 | 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET ADI | DRESS CITY S | STATE, ZIP CODE | | |
| TO WILL OF I | NOVIDEN ON OUT LIEN | | | | 777712, 211 0002 | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | | INS ROAD | | | |
| | | | SHANNO | N, NC 28386 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIEN | NCIES | ID | PROVIDER'S PLAN OF CORRECTION | N | (X5) |
| PRÉFIX | | MUST BE PRECEDED | | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFO | RMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | | | | | DEI IOIENOT) | | |
| V 367 | Continued From pa | ge 14 | | V 367 | | | |
| | | | | | | | |
| | Secretary. The rep | ort may be subm | itted via mail, | | | | |
| | in person, facsimile | or encrypted ele | ctronic | | | | |
| | means. The report | shall include the | following | | | | |
| | information: | | · · | | | | |
| | (1) reporting | provider contact | and | | | | |
| | identification inform | | | | | | |
| | | ntification informa | tion: | | | | |
| | (3) type of inc | | , | | | | |
| | | n of incident; | | | | | |
| | | he effort to deter | mine the | | | | |
| | cause of the incider | | | | | | |
| | | π, ਕਜਰ ⁄iduals or authori | tice petified | | | | |
| | ` ' | riduais di adilibil | lies notined | | | | |
| | or responding. | D massidana abal | برمام ماماماد | | | | |
| | (b) Category A and | | | | | | |
| | missing or incomple | | | | | | |
| | shall submit an upd | | | | | | |
| | report recipients by | the end of the ne | ext business | | | | |
| | day whenever: | | | | | | |
| | | er has reason to | | | | | |
| | information provide | | | | | | |
| | erroneous, mislead | | | | | | |
| | | er obtains inform | | | | | |
| | required on the inci- | dent form that wa | as previously | | | | |
| | unavailable. | | | | | | |
| | (c) Category A and | B providers shal | l submit, | | | | |
| | upon request by the | LME, other info | rmation | | | | |
| | obtained regarding | the incident, inclu | ıding: | | | | |
| | | ecords including of | | | | | |
| | information; | 3 | | | | | |
| | | other authorities | ; and | | | | |
| | | er's response to | | | | | |
| | (d) Category A and | | | | | | |
| | of all level III incide | | | | | | |
| | Mental Health, Dev | | | | | | |
| | Substance Abuse S | | | | | | |
| | | | | | | | |
| | becoming aware of | | | | | | |
| | providers shall send | | | | | | |
| | incidents involving a | | | | | | |
| | Health Service Reg | ulation within 72 | nours of | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPP IDENTIFICATION N | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
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| | | MHL078-159 | | B. WING | | | R 02/2021 |
| | PROVIDER OR SUPPLIER | | 220 CALV | DRESS, CITY, S INS ROAD N, NC 28386 | STATE, ZIP CODE | | - |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFOR | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 367 | becoming aware of client death within sor restraint, the pro- immediately, as req. 0300 and 10A NCA (e) Category A and report quarterly to the catchment area who the report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a le (3) searches (4) seizures of the possession of a (5) the total mincidents that occur | the incident. In caseven days of use of vider shall report the puired by 10A NCAGAC 27E .0104(e)(18 B providers shall she LME responsible ere services are prosubmitted on a formation as follown errors that do not all or level III incident interventions that evel II or level III incident interventions that evel II or level III incident interventions that evel III or level III incident interventions that evel II or level III incident interventions that evel II or level III incident interventions that evel III or level III and entindicating that the incidents whenevel irred during the quieria as set forth in talle and Subparagr | of seclusion be death C 26C B). Send a se for the ovided. In provided and shall as: t meet the nt; do not meet sident; ing area; property in and level III mere have arter that Paragraphs | V 367 | | | |
| | This Rule is not me Based on record re facility failed to repo home and host Loc as required. The fin | views and interview ort a critical inciden al Management Er | v, the t to the | | | | |

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Division of Health Service Regulation STATE FORM

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPFIDENTIFICATION | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
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| V 367 | Continued From pa | ge 16 | | V 367 | | | |
| | Review on 06/01/22 Response Improver revealed no level II unplanned restrictive client #1 for 04/12/2 | ment System (IRIS incident report for re intervention imp 21. | S) website an elemented on | | | | |
| | Review on 06/01/20 revealed: -11 year old maleAdmission date of -Diagnoses of Depr Attention Deficit Hy Unspecified Anxiety Defiant Disorder an | 02/05/21. ressive Mood Disc peractivity Disorde Disorder, Opposi | order, er, itional | | | | |
| | DisorderTreatment Plan up -Treatment plan did of restrictive interve | dated on 03/17/21 I not authorize pla | l. | | | | |
| | Review on 06/01/21 Department of Hea incident report for concident: 01 Date of Incident: 02 Time of Incident: 03 Description: See an Staff involved: Staff inv | Ith and Human Selient #1 revealed: 4/12/21. :00pm ttached page. If #2 and staff #3. Ite 4/12/21 On 4/2 In negative behavior Ite wasn't getting his Ite and tearing up his Ite and teari | 1/21 [Client or about s way. s room, s clothes. acility and he office, he nember and he away from negative ng profanity. | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPI IDENTIFICATION N | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | SURVEY PLETED |
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| | | MHL078-159 | | B. WING | | | R 02/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
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| V 367 | push member away restrain him. Memb down. He continued Staff escorted mem could calm down" Interview on 06/02/2-She understood ar restrictive interventia Level II IRIS repo-She would ensure completed. This deficiency has original cite on 10/2 within 30 days. | v several times and er was not trying to do to show negative aber to his room so 21 the Licensee standard use of on for clients should recorrect documentate been cited 3 times 4/19 and must be of the way of the correct documentate been cited 3 times 4/19 and must be of the way of the w | o calm behavior. that he ated: a ld result in tion was a since the corrected | V 367 | | | |
| V 521 | 27E .0104(e9) Clier 10A NCAC 27E .01 PHYSICAL RESTRIME-OUT AND PRESTRIME-OUT AND PR | O4 SECLUSIO RAINT AND ISOLAT ROTECTIVE DEVICE. CONTROL where restrictive ir colicy and procedure the following provise trictive intervention Il be made in the cla mum: client's physical and peing; requency, intensity avior which led to the proper of the behavior the use of the intervented and the inadequal | nterventions es shall be sions: is utilized, ient record and and ne umstance or; rvention, tions acy of less | V 521 | | | |

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
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| V 521 | (D) a description of time and duration of (E) a description of methods of interver (F) a description of with the client and t if applicable, for the physical restraint or reduce the probarestrictive interventi (G) a description of with the client and t if applicable, for the physical restraint or determined to be cl (H) signature and ti | If the intervention and to fits use; accompanying position; the debriefing and place emergency use of secretary is accompanying position; the legally responsible emergency use of secretary is the future use is the debriefing and place eplanned use of seclusions; is the debriefing and place planned use of seclusion is considered in the legally responsible explanned use of seclusion in the legally responsible explanned use of seclusion in the facility employers the employee who fit in the employee who fit in the second in the seco | anning person, eclusion, eliminate of anning person, esion, d oyee | V 521 | | | |
| | facility failed to ens documentation was restrictive intervention of three clients (#1) Review on 06/01/2 revealed: -11 year old maleAdmission date of -Diagnoses of Depri Attention Deficit Hy Unspecified Anxiety Defiant Disorder an DisorderNo documentation | views and interviews, ure the necessary in the client record within the client record within the client record within the findings are: 1 of client #1's record 02/05/21. ressive Mood Disorde peractivity Disorder, opposition of Post Traumatic Street of required information was implemente | rhen a ing one r, al ess | | | | |

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPI | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
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| | | MHL078-159 |) | B. WING | | | R 02/2021 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
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| V 521 | Continued From pa | ge 19 | | V 521 | | | |
| | Review on 06/01/21 Department of Heal incident report for c-Date of Incident: 04 -Time of Incident: 54 -Description: See at Staff involved: Staff-"Progress Note Da #1] begin displaying 5:00pm because he Member began kick destroying his room Member started wa into office. When m grabbed the phone several times to giv refused. Staff had to member. Member behavior towards staff Member began bull was going to hit her push member away restrain him. Member down. He continued Staff escorted mem could calm down" Interview on 06/02/2-She understood ar restrictive interventia a Level II IRIS reposhe understood redocumentation on the debriefing and methes she would ensure completed. | Ith and Human Selient #1 revealed: 4/12/21. :00pm ttached page. If #2 and staff #3. Ite 4/12/21 On 4/2 In negative behavior wasn't getting his ing the walls in his and tearing up his liking around the frember went into the Staff prompted met the phone back to take the phone active the phone so take the phone in the several times. Staff and active several times. Staff and active several times and the several times are several times and the several times and the several times and the several times are several times. | ervices 21/21 [Client or about s way. s room, is clothes. acility and he office, he nember and he away from negative ng profanity. ed like he aff had to do calm e behavior. The othat he tated: of a uld result in ons required at, time, on. | | | | |

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Division of Health Service Regulation STATE FORM

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | 71. BOILDING. | | F | ₹ |
| | | MHL078-159 | B. WING | | | 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | INS ROAD N, NC 28386 | 3 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 536 | Continued From pa | ge 20 | V 536 | | | |
| V 536 | 27E .0107 Client Ri Int. | ghts - Training on Alt to Rest. | V 536 | | | |
| | practices that emph to restrictive interverse (b) Prior to providing disabilities, staff incompleting training employees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agence based on state composed on state composed on state compliance and degathered. (d) The training shate include measurable testing behavior) on those methods to determine course. (e) Formal refreshed by each service programually). (f) Content of the training of MH// Paragraph (g) of this (g) Staff shall deminfollowing core areas | mplement policies and nasize the use of alternatives entions. Ing services to people with eluding service providers, as or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or prevented. It is shall establish training inpetencies, monitor for internal monstrate they acted on data all be competency-based, written and by observation of objectives and measurable in passing or failing the er training must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to its Rule. Constrate competence in the is: e and understanding of the | | | | |

| MHL078-159 MHL078-159 STREET ADDRESS, CITY, STATE, ZIP CODE 220 CALVINS ROAD SHANNON, NC 28386 (X4) ID SHANNON, NC 28386 (X5) SHANNON, NC 28386 (X6) SHANNON | | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | LE CONSTRUCTION | | SURVEY PLETED |
|--|---------|---|---|----------------|---------------------------|---------|------------------|
| NAME OF PROVIDER OR SUPPLIER A BETTER WAY RESIDENTIAL SERVICES A SETTER WAY RESIDENTIAL SERVICES 220 CALVINS ROAD SHANNON, NC 28386 (A41)D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAY SEE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 21 V 536 Continued From page 21 (2) recognizing and interpretting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the | | | | 7. BOILDING | · | | R |
| A BETTER WAY RESIDENTIAL SERVICES 220 CALVINS ROAD SHANNON, NC 28386 (CA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 21 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the | | | MHL078-159 | B. WING | | | |
| (24) ID PREFIX TAG SIMMARY STATEMENT OF DEFICIENCIES TAG SIMMARY STATEMENT OF DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 21 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the | NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | |
| CX4] ID PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX | A BETTE | ER WAY RESIDENTIAL | I SERVICES | | 6 | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 21 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe), (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the | (X4) ID | SUMMARY STA | | | T | RECTION | (X5) |
| (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the | PREFIX | | | PREFIX | CROSS-REFERENCED TO THE A | | COMPLETE |
| behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the | V 536 | Continued From pa | age 21 | V 536 | | | |
| (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. | V 530 | (2) recognizing behavior; (3) recognizing external stressors to disabilities; (4) strategies relationships with post organizational factor disabilities; (6) recognizing assisting in the perfect decisions about the community of | ng and interpreting human ng the effect of internal and that may affect people with s for building positive persons with disabilities; ng cultural, environmental an ors that may affect people wit ng the importance of and son's involvement in making eir life; ssessing individual risk for r; ication strategies for defusing potentially dangerous behavion pehavioral supports (providing with disabilities to choose ectly oppose or replace er unsafe). ers shall maintain nitial and refresher training for s. ntation shall include: cipated in the training and the ill); d where they attended; and r's name; sion of MH/DD/SAS may documentation at any time. fications and Training shall demonstrate competence in testing in a training program g, reducing and eliminating the | din | | | |

| DIVISION | of Health Service Re | egulation | • | | | | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILD | NG: | | COMPL | -E1ED |
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| | | WITILU76-159 | 2 | | | 06/0 | 2/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STR | REET ADDRESS, CI | TY, STATE, ZIP CODE | | | |
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| A BETTE | R WAY RESIDENTIAL | I SERVICES | ANNON, NC 28 | | | | |
| | | | ANNON, NC 20 | | | ı | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | | AN OF CORRECTION | | (X5) COMPLETE |
| PREFIX TAG | ` | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION | | | VE ACTION SHOULD ED TO THE APPROPF | | DATE |
| 170 | | | , 140 | | FICIENCY) | | |
| | | | | | | | |
| V 536 | Continued From pa | age 22 | V 536 | | | | |
| | by cooring a passin | a grada an taating in an | | | | | |
| | | ng grade on testing in an | | | | | |
| | instructor training p | | | | | | |
| | | ing shall be | | | | | |
| | | l, include measurable lear | | | | | |
| | | able testing (written and b | | | | | |
| | | avior) on those objectives | | | | | |
| | measurable method | ds to determine passing o | or | | | | |
| | failing the course. | | | | | | |
| | (4) The conte | ent of the instructor trainir | ng the | | | | |
| | service provider pla | ans to employ shall be | | | | | |
| | | vision of MH/DD/SAS pur | suant | | | | |
| | to Subparagraph (i) | | | | | | |
| | | ole instructor training prog | rams | | | | |
| | | e not limited to presentati | | | | | |
| | | nding the adult learner; | 0.1. 0.1. | | | | |
| | | for teaching content of th | | | | | |
| | course; | for teaching content of the | .6 | | | | |
| | , | for evaluating trainee | | | | | |
| | performance; and | ioi evaluating trainee | | | | | |
| | | tation procedures | | | | | |
| | | tation procedures. | | | | | |
| | ` ' | shall have coached exper | | | | | |
| | | program aimed at prever | | | | | |
| | | nating the need for restric | tive | | | | |
| | | st one time, with positive | | | | | |
| | review by the coach | | | | | | |
| | | shall teach a training prog | | | | | |
| | | g, reducing and eliminatin | | | | | |
| | need for restrictive | interventions at least onc | e | | | | |
| | annually. | | | | | | |
| | (8) Trainers | shall complete a refreshe | r | | | | |
| | | nt least every two years. | | | | | |
| | (j) Service provider | | | | | | |
| | | nitial and refresher instruc | ctor | | | | |
| | training for at least | | | | | | |
| | | mentation shall include: | | | | | |
| | \ <i>\</i> | cipated in the training and | l the | | | | |
| | outcomes (pass/fai | | | | | | |
| | | d where attended; and | | | | | |
| | | | | | | | |
| | (C) instructor | i s name. | | | | | |

Division of Health Service Regulation

STATE FORM 6899 4L0Q11 If continuation sheet 23 of 32

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPI IDENTIFICATION | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | SURVEY PLETED |
|--------------------------|---|---|---|---|--|----------------------------------|--------------------------|
| | | MHL078-159 | 9 | B. WING | | | R 02/2021 |
| | PROVIDER OR SUPPLIER | _ SERVICES | 220 CALV | DRESS, CITY, S I'INS ROAD N, NC 28386 | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOI | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 536 | (2) The Division request and review (k) Qualifications of (1) Coaches requirements as a to (2) Coaches the course which is | tion of MH/DD/SAS this documentation f Coaches: shall meet all preparainer. shall teach at least being coached. shall demonstrate appletion of coaching | on any time. caration st three times and or | V 536 | | | |
| | This Rule is not me Based on record re interviews the facilit audited paraprofess trained and demons Alternatives to Rest findings are: Review on 6/2/21 or -Original hire date 9-Most recent rehire -Nonviolent Crisis In completed on 10/3/2-"Coaching Docume 11/11/20 Immediate Child Abuse On Tue [Qualified Profession call from the managissues with a consuland heard you raise | view, observation by failed to assure sional staff (#1, #1 strated competent trictive Intervention of staff #1's record 10/10/19. date 5/11/21. Intervention Training 20. Intervention Training Termination "Occurred y November and (QP)] the QP oper [previous staff timer. [QP] entered | and two of four 10) were cy in ns. The revealed: #1 dated currence: 10th 2020, received a] about d the facility | | | | |

Division of Health Service Regulation

STATE FORM 6899 4L0Q11 If continuation sheet 24 of 32

| DIVISION | of Health Service Re | egulation | | | | |
|--|---|--|---------------------|---|-----------|--------------------------|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | | | | F |) |
| | | MHL078-159 | B. WING | | | \ 2/2021 |
| | | WITE070-133 | | | 00/0 | 2/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A DETT | D WAY DEGIDENTIAL | SERVICES 220 CALV | INS ROAD | | | |
| A BETTER WAY RESIDENTIAL SERVICES SHANNO | | | N, NC 28386 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| V 536 | Continued From pa | ge 24 | V 536 | | | |
| | the client, the client and threatening hin The client requeste and that we would I treating them This a the camera. On car using profanity towatelling the client that a**You were anta arguing with the client at least thirty minutell started because go outsideYour all the clients is a serie with you before. Yo home with younger would be able to interprofessional manner additional training. Train training is to teach clients. You have not utilize use any of the You were removed facility] schedule for was investigated by and Human Service the client, you ender Your coworker attent the situation and you interact with the clieverbally abusive, the which is not helpful needs, you are beir -There was no door to show he had been are the situation and been above the shown he had been and the situation and been shown he had been are the situation and you are beir -There was no door to show he had been are the situation and been shown he had been and the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are beir -There was no door to show he had been are the situation and you are situation and you are beir -There was no door to show he had been are the situation and you are situation and you a | accused you of cursing at him in. Which you denied doing. In that the camera be reviewed be able to see how you were action prompted [QP] to review mera, you are seen and heard ards the client. You are heard it you would body slam his agonizing the client and ent. This incident went on for es. The client stated that his the client's asked if they can bility to de-escalate yourself or ous issue that we addressed in were moved to a different clients in hopes that you steract with them in a more er. We have provided you with NCI plus as well as clients hing The purpose of the NCI you how to de-escalate the ot demonstrated the ability to be techniques taught to you, from the other home, [sister or the same type incident that you plant to intercede and defuse ou refused. Because you ents in a manner that is increatening and is traumatic towards their treatment and ang terminated immediately." umentation in staff #1's record en trained and demonstrated ernative to Restrictive | | | | |

Review on 6/2/21 of the facility's personnel
Division of Health Service Regulation
STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---|-------------------------|---|------------------------------|--------------------------|
| | | B. WING | | | R | | |
| | | MHL078-15 | i9 | D. WING | | 06/ | 02/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | | INS ROAD N, NC 28386 | 3 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO | D BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| V 536 | records revealed: -No record for staff -No documentation Alternatives to Rest providing services. Observation on 6/1/revealed: -Staff #10 arrived a to orientationThe House Manag Interview on 6/1/21 -He recently had to restraint. Interview on 6/1/21 -It was her first day -She was at the fac Interview on 6/1/21 Manager stated: -She was not sure a terminationStaff #10 was only -She had been train been trained in NCI Interview on 06/02/2 understood all staff in alternatives to res | #10. she was trained trictive Intervention /21 at approxima t facility to shado er arrived at the staff #1 stated: place client #1 in staff #10 stated: at the facility. illity to shadow staff #1's pace at the facility st | tely 9:25am w staff prior facility. n a physical aff. louse revious shadow. aff #1 had stated she have training | V 536 | | | |
| V 537 | providing services. 27E .0108 Client Ri ITO | ights - Training in | Sec Rest & | V 537 | | | |
| | 10A NCAC 27E .01 SECLUSION, PHYS ISOLATION TIME-0 | SICAL RESTRAI | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------------------------|---|--------|-------------------------------|--|
| | | A. BUILDING: | | R | | | |
| MHL078-159 | | B. WING | | | 2/2021 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| A BETTEI | R WAY RESIDENTIAL | SERVICES | INS ROAD | | | | |
| | OLUMBA DV OTA | | N, NC 28386 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 537 | Continued From pa | ge 26 | V 537 | | | | |
| | (a) Seclusion, physitime-out may be enbeen trained and hacompetence in the to these procedures staff authorized to exprocedures are retrompetence at least (b) Prior to providin disabilities whose trincludes restrictive service providers, evolunteers shall conseclusion, physical and shall not use the training is completed demonstrated. (c) A pre-requisited demonstrating completed demonstration completed demonst | sical restraint and isolation aployed only by staff who have ave demonstrated proper use of and alternatives is. Facilities shall ensure that employ and terminate these ained and have demonstrated is annually. If it is given the extrement is a staff including employees, students or emplete training in the use of restraint and isolation time-out it is earned to extrain the extrement interventions until the extreme interventions. If it is petence by completion of extreme interventions in the use of restraint and isolation time-out it is petence by completion of extreme interventions. If it is petence is extraining and eliminating the interventions in the use of restraining objectives, (written and by observation of objectives and measurable interventions in the use of restraining must be completed exider periodically (minimum in that the service in the service in the programs is all include, or, presentation of: information on alternatives to | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|--|------|------------------------------|--|
| | | | , | | R | | |
| | | MHL078-159 | B. WING | | | 2/2021 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| A BETTE | R WAY RESIDENTIAI | SERVICES | INS ROAD | | | | |
| | | SHANNOI | N, NC 28386 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 537 | Continued From pa | ge 27 | V 537 | | | | |
| v 337 | (understanding immothers); (3) emphasis rights and dignity of concepts of least reincremental steps if (4) strategies of restrictive interverses (5) the use of interventions which assessment and mpsychological well-luse of restrictive intervent (6) prohibited (7) debriefing importance and pur (8) document (9) document (10) Service provided documentation of in at least three years (1) Document (11) Document (12) The Divis review/request this (13) Instructor Qualif Requirements: (14) Trainers is by scoring 100% or aimed at preventing need for restrictive (25) Trainers is by scoring 100% or teaching the use of and isolation time-or concepts of the strain | ninent danger to self and son safety and respect for the fall persons involved (using estrictive interventions and nan intervention); sofor the safe implementation entions; femergency safety include continuous onitoring of the physical and being of the client and the safe bughout the duration of the ion; I procedures; g strategies, including their rose; and tation methods/procedures. Its shall maintain nitial and refresher training for that the training and the lip; I where they attended; and shall include: cipated in the training and the lip; I where they attended; and shall demonstrate competence in testing in a training program g, reducing and eliminating the interventions. Shall demonstrate competence in testing in a training program seclusion, physical restraint | | | | | |

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|--|------|-------------------------------|--|
| | | | | | R | | |
| | | MHL078-159 | B. WING | | | 2/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| A BETTE | R WAY RESIDENTIAL | SERVICES | INS ROAD | | | | |
| | | | N, NC 28386 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 537 | Continued From pa | ge 28 | V 537 | | | | |
| V 537 | by scoring a passin instructor training p (4) The trainic competency-based objectives, measured objectives, measured observation of behasing the course. (5) The contest of alling the course. (5) The contest of approved by the Divito Subparagraph (j) (6) Acceptability of the shall include, but notest of the service provider plates approved by the Divito Subparagraph (j) (6) Acceptability of the shall include, but notest of the service provider platest of the service provider platest of the service provider platest of the course; (C) evaluation (D) document (T) Trainers of the service provider of the service of t | g grade on testing in an rogram. ng shall be , include measurable learning able testing (written and by avior) on those objectives and ds to determine passing or ent of the instructor training the ans to employ shall be vision of MH/DD/SAS pursuant | V 537 | | | | |
| | (k) Service provide | ers shall maintain nitial and refresher instructor | | | | | |

Division of Health Service Regulation

STATE FORM 6899 4L0Q11 If continuation sheet 29 of 32

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|-------------------------|--|-----------|-------------------------------|--|
| | | MHL078-159 | | | F 06/0 | ₹ 2/2021 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 1 00/0 | 2/2021 | |
| A BETTE | ER WAY RESIDENTIAI | SERVICES | INS ROAD N, NC 28386 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 537 | (1) Document (A) who particular outcome (pass/fail) (B) when and (C) instructor (2) The Division review/request this (I) Qualifications of (1) Coaches requirements as a factor (2) Coaches times, the course work (3) Coaches competence by contrain-the-trainer instruction. | atation shall include: cipated in the training and the cipated in the training and the training and the cipated in the training and | V 537 | | | | |
| | interviews, the facil audited staff were to demonstrated comprestraint and isolation. Review on 6/2/21 or -Original hire date sometime -Nonviolent Crisis I completed on 10/3/2-"Coaching Docume 11/11/20 Immediate Child Abuse On Ture [Qualified Profession call from the management of the complete of the | rviews, observation and ity to assure two of five rained (#1, #10) or petency in seclusion, physical on time-out. The findings are: of staff #1's record revealed: 0/10/19. date 5/11/21. ntervention Training (NCI) | | | | | |

Division of Health Service Regulation

STATE FORM 6899 4L0Q11 If continuation sheet 30 of 32

| ווטופועום | Division of Health Service Regulation | | | | | | |
|-------------------|---------------------------------------|---------------------------------|----------------|---------------------------------|-----------|------------------|--|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | (X2) MULTIPLE CONSTRUCTION (X3) | | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | · | COMPLETED | | |
| | | | | | | , | |
| | | MHL078-159 | B. WING | | 06/0 | 2/2021 | |
| | | WITE076-139 | | | 1 00/0 | 2/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | | |
| | | 220 CA | LVINS ROAD | | | | |
| ABEITE | R WAY RESIDENTIAL | L SERVICES SHANN | ON, NC 28386 | 3 | | | |
| (V4) ID | SHIMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTI | | (VE) | |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE | |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO | PRIATE | DATE | |
| | | | | DEFICIENCY) | | | |
| V 537 | Continued From pa | age 30 | V 537 | | | | |
| , , | - | - | | | | | |
| | | ed voice. When he spoke wit | | | | | |
| | | t accused you of cursing at h | m | | | | |
| | and threatening hin | n. Which you denied doing. | | | | | |
| | The client requeste | ed that the camera be reviewe | ed | | | | |
| | and that we would I | be able to see how you were | | | | | |
| | treating them This a | action prompted [QP] to revie | •w | | | | |
| | the camera. On car | mera, you are seen and hear | d | | | | |
| | using profanity towa | ards the client. You are heard | | | | | |
| | telling the client tha | it you would body slam his | | | | | |
| | | agonizing the client and | | | | | |
| | | ent. This incident went on for | | | | | |
| | | es. The client stated that his | | | | | |
| | | the client's asked if they can | | | | | |
| | | bility to de-escalate yourself | | | | | |
| | | ous issue that we addressed | | | | | |
| | | u were moved to a different | | | | | |
| | | clients in hopes that you | | | | | |
| | , , | teract with them in a more | | | | | |
| | | er. We have provided you wit | h | | | | |
| | | NCI plus as well as clients | | | | | |
| | | ning The purpose of the NCI | | | | | |
| | | you how to de-escalate the | | | | | |
| | | ot demonstrated the ability to | | | | | |
| | | e techniques taught to you. | | | | | |
| | | from the other home, [sister | | | | | |
| | | or the same type incident that | | | | | |
| | | y DHHS (Department of Heal | | | | | |
| | | es). IN your attempt to restra | | | | | |
| | | ed up almost fighting the clier | | | | | |
| | | mpted to intercede and defus | | | | | |
| | | ou refused. Because you | | | | | |
| | | ents in a manner that is | | | | | |
| | | reatening and is traumatic | | | | | |
| | | towards their treatment and | | | | | |
| | | | | | | | |
| | | ng terminated immediately." | 4 | | | | |
| | | umentation in staff #1's recor | u | | | | |
| | to show he had bee | | _, | | | | |
| | | petency on seclusion, physic | ai | | | | |
| | restraint and isolation | on time since his rehire. | | | | | |

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Division of Health Service Regulation STATE FORM

| NAME OF PROVIDER OR SUPPLIER A BETTER WAY RESIDENTIAL SERVICES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 220 CALVINS ROAD SHANNON, NC 28386 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---|---|--|--|---------|--|-------------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER A BETTER WAY RESIDENTIAL SERVICES SUMMARY STATEMENT OF DEFICIENCIES SHANNON, NC 28386 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 31 Review on 6/2/21 of the facility's personnel records revealed: -No record for staff #10No documented training in seclusion, physical restraint and isolation time-out prior to providing | | | 7. BOILBING. | | F | ₹ | |
| A BETTER WAY RESIDENTIAL SERVICES 220 CALVINS ROAD SHANNON, NC 28386 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 31 Review on 6/2/21 of the facility's personnel records revealed: -No record for staff #10No documented training in seclusion, physical restraint and isolation time-out prior to providing | MHL078-159 | | | B. WING | | 06/0 | 2/2021 |
| A BETTER WAY RESIDENTIAL SERVICES SHANNON, NC 28386 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 31 Review on 6/2/21 of the facility's personnel records revealed: -No record for staff #10No documented training in seclusion, physical restraint and isolation time-out prior to providing | NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 31 Review on 6/2/21 of the facility's personnel records revealed: -No record for staff #10No documented training in seclusion, physical restraint and isolation time-out prior to providing (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 537 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 537 | A BETTI | ER WAY RESIDENTIA | I SERVICES | | 3 | | |
| Review on 6/2/21 of the facility's personnel records revealed: -No record for staff #10No documented training in seclusion, physical restraint and isolation time-out prior to providing | PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR | JLD BE | (X5) COMPLETE DATE |
| records revealed: -No record for staff #10No documented training in seclusion, physical restraint and isolation time-out prior to providing | V 537 | Continued From pa | nge 31 | V 537 | | | |
| Observation on 6/1/21 at approximately 9:25am revealed: -Staff #10 arrived at facility to shadow staff prior to facility orientationThe House Manager arrived at the facility. Interview on 6/1/21 staff #1 stated: -He recently had to place client #1 in a physical restraint. Interview on 6/1/21 staff #10 stated: -It was her first day at the facilityShe was at the facility to shadow a staff member. Interview on 6/1/21 and 6/2/21 the House Manager stated: -She was not sure about staff #1's previous terminationStaff #10 was only at the facility to shadow staff prior to beginning workShe had been trained in NCI and staff #1 had been trained in NCI in the event a physical restrictive intervention was needed. Interview on 06/02/21 the Licensee stated she understood all staff were required to receive training in seclusion, physical restraint and isolation time prior to providing services. | V 537 | Review on 6/2/21 or records revealed: -No record for staff -No documented transcription on 6/1 revealed: -Staff #10 arrived at to facility orientation -The House Manage Interview on 6/1/21 -He recently had to restraint. Interview on 6/1/21 -It was her first day -She was at the fact Interview on 6/1/21 Manager stated: -She was not sure terminationStaff #10 was only prior to beginning well and been trained in NC restrictive intervent Interview on 06/02/ understood all staff training in seclusion | of the facility's personnel if #10. aining in seclusion, physical on time-out prior to providing /21 at approximately 9:25am at facility to shadow staff prior in. ger arrived at the facility. staff #1 stated: place client #1 in a physical staff #10 stated: at the facility. cility to shadow a staff member. and 6/2/21 the House about staff #1's previous at the facility to shadow staff work. ned in NCI and staff #1 had I in the event a physical ion was needed. (21 the Licensee stated she if were required to receive in, physical restraint and | | | | |

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Division of Health Service Regulation
STATE FORM