STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on September 22, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop goals & strategies to meet the needs for 1 of 3 audited clients (#4). The findings are: Review on 9/16/21 & 9/20/21 of client #4's record revealed: - diagnoses of Schizoaffective Disorder, Moderate Intellectual Developmental Disability, Diabetes Uncomplicated Type II, High Blood Pressure, Hyperlipidemia and Obesity - treatment plan dated 9/1/21 - "...Behavioral: I display both verbal and physical aggression since childhood... include making verbal threats to hurt others, attacking others with a knife and being physically aggressive towards caretakers..." - no goals or strategies to address attacking others with a knife Observation on 9/22/21 at 3:16pm revealed an unlocked cabinet with knives During interview on 9/15/21 client #4 reported: - upset with staff #8 - she pulled out a knife on her the other day During interview on 9/15/21 staff #8 reported: - client #4 wanted more cookies after dinner even though she was already given 4 chocolate chip cookies. Client #4 was a diabetic. Client #4 went to her bedroom & came back to the kitchen. She pulled out a butcher knife & threatened to kill her. She redirected her to put the knife back in the kitchen drawer. She did & returned to her bedroom. She checked on her 15 minutes later and she was fine. She hid the knives in the sink	V 112	**V112** Residential Tx. Plan will be revised to address health and safety need of Client #4 by Care Coordinator through QP. Going forth, QP will develop goals and strategies to specifically address the individual health and safety needs of individual. Behavioral plan also being developed by psychiatrist to address needs.	11-21-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 2 cabinet. She doesn't know about anything in client #4's treatment plan in reference to her attacking anyone with a knife During interview on 9/15/21 staff #7 reported: - it was a week or two ago. Client #4 wanted more cookies and staff #8 informed her she could not have anymore. She went to her bedroom and started to slam her closet door. Staff #8 offered her more cookies and she "snatched" them from staff #8. Staff #8 took the cookies back and informed her she could get more tomorrow. She (staff#7) went outside and called her mother (staff #12). Staff #12 told her to wait until client #4 calmed down and then speak with her. She came back in the facility & client #4 asked to speak with her. She told her (staff #7) she pulled a knife on staff #8 but she was sorry & did not want the police to come. She talked with client #4 until she was calm. Checked on her 15 minutes later and she was fine. She was not aware there was anything in client #4's treatment plan in reference to her attacking anyone with a knife During interview on 9/15/21 the Residential Director #1 reported: - she was not aware of the incident between client #4 & staff #8 - client #4 had a history of making verbal threats & physical aggression - was not aware she had a history of attacking anyone with a knife During interview on 9/21/21 client #4's care manager reported: - she was not aware of an incident between client #4 & staff #8 - client #4 exhibits verbal & physical aggression - 7 or 8 years ago client #4 said she attacked a	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 3 family member and caregivers with a knife however, there was no proof of those behaviors by client #4 - she had been client #4's care manager since 2012 & it was already in her treatment plan - client #4 was her own guardian and had not requested any information be removed from the treatment plan - a behavior plan may need to be discussed for client #4's behaviors During interview on 9/22/21 the Chief Executive Officer reported: - the Qualified Professional and the psychiatrist planned to discuss a behavior plan to address client #4's behaviors	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by:	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 4 Based on record review and interview the facility failed to ensure fire & disaster drills were completed quarterly and on each shift. The findings are: Review on 9/20/21 of the facility's fire & disaster drill log revealed: - no documented drills from January 2021 - September 2021 During interview on 9/15/21 client #2 reported: - been at the facility about 3 years - didn't know what to do if there was a fire - after continued interview he would go outside - he would get in a closet for a tornado - didn't know if fire or tornado drills were practiced at the facility During interview on 9/16/21 staff #7 reported: - worked at the facility for a year - had not completed fire & disaster drills - she was not informed where to take clients during fire & tornado drills - if there was a fire, clients would go outside - tornado drills in their closet During interview on 9/21/21 the Residential Director #2 reported: - she filled in as RD due to RD#1 being out since July 2021 - RD#1 ensured drills were completed - staff are supposed to complete fire & disaster drills - doesn't know how to check the electronic system to see if drills were done - She has not participated in any fire or disaster drills this year [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days].	V 114	V114: Drills were present for this home however, the wrong months were presented to reviewer. Residential Director Supervisor will inservice fill in Residential Director or hired Residential Director on how to access drills through Therap. Residential Director will also inservice all staff about procedures on how to conduct drills and to complete in Therap. RD supervisor will complete monthly checks through Therap to ensure drills are completed per agency policy and noted in collaborative note noting recommendations if need be or noting that drills were completed appropriately. Agency is in process of hiring a permanent Residential Director for the home.	10-22-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 6 Based on record review and interview the facility failed to ensure MARs were kept current for 1 of 3 current client (#4) & 1 of 1 former client (FC#2). The findings are: A. Review on 9/16/21 & 9/20/21 of client #4's record revealed: - diagnoses of Schizoaffective Disorder, Moderate Intellectual Developmental Disability, Diabetes Uncomplicated Type II, High Blood Pressure, Hyperlipidemia and Obesity - physician order dated 9/1/21 Metformin 500mg (milligram) twice a day (diabetes) Amlodipine 10mg daily (high blood pressure) Losartan Potassium 25mg daily (high blood pressure) Haloperidol 5mg daily (mental disorders) Fluoxetine 40mg 2 PO daily (depression) Divalproex 250mg twice day & 500mg twice a day (bipolar disorder) Atorvastatin 10mg bedtime (high cholesterol) Trazadone 100mg bedtime (depression) Review on 9/20/21 of client #4's MAR revealed - blank spaces 9/1/21; 9/2/21 & 9/14/21 for all the above medications - Divalproex blank spaces from 9/1/21 - 9/14/21 During interview on 9/21/21 the pharmacist reported: - physician orders were sent to her on 9/1/21 - client #4 was admitted with some of her medications & some she did not have - she filled the medications she did not have when she was admitted - the Divalproex was not filled until 9/8/21 when staff said they ran out - medications are sent overnight	V 118	V118 Staff to be retrained on medication administration with emphasis on MARs being kept current by RN. (10-12-21) RN will provide oversight on monthly basis to ensure MARs are current and new medications are added to quickmar upon receipt. Residential will review QuickMar weekly to ensure MAR is current and complete collaborative note noting such in each person's chart.	11-21-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 7 During interview on 9/21/21 the Residential Director #2 reported: - filled in for RD#1 since July 2021 for last 2 months - RD#1 provided some training on the medication electronic system (MES) - she checked the MARs daily and did not find any errors - RD#1 told her to check for red flags in the (MES) but she had not witnessed any - she had not seen any blank spaces on the MARS & did not know what the blank spaces meant - she last checked the MARs on Monday (9/20/21) - the Qualified Professional (QP) checked MARs after her - when client #4 first arrived to the facility, all her medications were not sent and she had to contact the pharmacy During interview on 9/21/21 the Clinical Director reported: - she does not oversee the MARs - staff could contact her or their supervisor for technical assistance with the MES - RD#2 should not look for red flags - needed to look for alerts - anything outside of 15 minutes of medication not passed, it will send an alert - the alert will let you know how many medications had not been passed - a management was held today and it was discussed staff seemed to be having issues with MES - some of the issues were the internet at the facility & some staff needed additional training B. Review on 9/20/21 of FC#3's record revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 8 - admitted 2/16/21 & discharged 8/23/21 - diagnoses of Moderate IDD, Mood Disorder with depressive type unspecified, Cerebral Palsy (right hem iplegia) & History of Seizures - FL2 dated 3/29/21: Gabapentin 100mg three times a day (seizures) Atarax 25mg four times a day (anxiety) Lamictal 200mg bedtime (seizures) Protonix 40mg daily (gastroesophageal reflux disease GERD) Desyrel 150mg bedtime (depression) Remeron 15mg daily (depression) Review on 9/20/21 of FC#3's July 2021 MAR revealed: - blank spaces on 14, 16, 17 &18 at 8pm for the above medications During interview on 9/22/21 the Clinical Director reported: - FC#3 was in the hospital on the days with the blank spaces - there still should have been a code in the blank spaces During interview on 9/17/21 the QP reported: - she reviewed MARs twice a month - there were no medication errors During interview on 9/21/21 the Lead Residential Supervisor reported: - she planned to retrain staff on the MES	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 9 level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 10 (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure level II incident reports were completed for 1 of 3 audited client (#4) & 1 of 1 former client (FC#2). The findings are: A. Review on 9/16/21 & 9/20/21 of client #4's record revealed: - diagnoses of Schizoaffective Disorder, Moderate Intellectual Developmental Disability, Diabetes Uncomplicated Type II, High Blood Pressure, Hyperlipidemia and Obesity Refer to V112 in regard to the incident between client #4 & staff #8 - client #4 pulled a knife on staff #8 after she could not get more cookies Review on 9/20/21 of the facility's incident report log revealed no incidents regarding client #4 pulling a knife on staff #8 During interview on 9/15/21 staff #8 reported: - she did not complete an incident report - she contacted Residential Director (RD#3) an informed her of the incident - RD#3 could have completed the incident report During interview on 9/15/21 RD#3 reported: - she was not aware of the incident between client #4 & staff #8, therefore she did not complete an incident report B. Review on 9/20/21 of FC#3's record revealed:	V 367	V367 Staff will be in-serviced incident reporting (Levels I, II, III) by Staff Development Coordinator and/or Lead QP. Residential Director will also inservice QP and RD on how to look for incident reports once entered into Therap for future needs. Lead QP and RD Supervisor will check with assigned QP and Residential Director weekly to inquire about any incidents that may have occurred and report findings in therap collaborative note.	11-21-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 12 - admitted 2/16/21 & discharged 8/23/21 - diagnoses of Moderate IDD, Mood Disorder with depressive type unspecified, Cerebral Palsy (right hem iplegia) & History of Seizures Review on 9/15/21 of an email dated 9/15/21 sent by the Qualified Professional (QP) revealed: - no incident reports for FC#3 for July 2021 & August 2021 Review on 9/21/21 of incident reports sent by the Clinical Director for FC#3 revealed: - 2 falls without injury - one level I dated 7/3/21 (client had a behavior) During interview on 8/30/21 staff #1 reported: - FC#3 was discharged due to property damage and verbal threats During interview on 9/20/21 FC#2's guardian reported: - FC#3 does not stay in placement long - she will exhibit behaviors to get discharged from a facility - she made verbal threats to an older lady (#1) to kill her - hospitalized 3-4 times while at the facility due to her behaviors - staff contacted her 4 days out of 7 days due to FC#3's behaviors During interview on 9/21/21 the Clinical Director reported: - FC#3 exhibited several behaviors while at the facility - some of the behaviors caused her to be hospitalized - she would view & send the incident reports	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL070-062	A. BUILDING: _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER CONNECTIONS-ELIZABETH CITY	1331 FOUR FORKS ROAD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 13 During interview on 9/22/21 the Operations Director reported: - there should have been incident reports for FC#3 During interview on 9/22/21 the Chief Executive Officer reported: - would send the incident report policy by close of survey exit date (9/22/21) - incident report policy was not received by close of survey exit date	V 367		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

September 24, 2021

dve
re-d
Surv

John Williams, Operation Director
Better Connections Inc.
PO Box 3381
Greenville, NC 27836

Re: Annual & Follow up Survey completed September 22, 2021
Better Connections-Elizabeth City 1331 Four Forks Road, Elizabeth City, NC 27909
MHL #070-062
E-mail Address: jwilliams@betterconnectionsinc.com

Dear Mr. Williams:

Thank you for the cooperation and courtesy extended during the Annual & Follow up survey completed September 22, 2021.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

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

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is October 22, 2021.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is November 21, 2021.

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. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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
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 at (919) 552-6847.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant