	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		A. BUILDING:		R 11/12/2021	
	MHL078-159	B. WING			
DER OR SUPPLIER	STRE	ET ADDRESS, CITY, STATE	, ZIP CODE		
	220 C	ALVINS ROAD			
I RESIDENTIAL SE	SHAI	NNON, NC 28386			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
TIAL COMMENTS	3	V 000			
npleted on Novem nplaint was substa C00180485). Defi is facility is license	nber 12, 2021. The antiated (Intake iciencies were cited. ed for the following service				
	ire for Children or				
G .0209 (C) Medic	ation Requirements	V 118			
QUIREMENTS Medication admin Prescription or no y be administered ler of a person aut igs. Medications shall ents only when aut ent's physician. Medications, inclu- ministered only by icensed persons the armacist or other level vileged to prepare A Medication Administere rent. Medications orded immediately a is to include the client's name; name, strength, a instructions for act date and time the name or initials of	istration: on-prescription drugs shall to a client on the written chorized by law to prescribe be self-administered by chorized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. ninistration Record (MAR) of d to each client must be kept administered shall be y after administration. The e following: and quantity of the drug; dministering the drug; e drug is administered; and				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR TIAL COMMENTS complaint and follo mpleted on Novem mplaint was substa C00180485). Def is facility is license regory: 10A NCAC atment Staff Secu- olescents. G .0209 (C) Medic A NCAC 27G .020 CQUIREMENTS Medication admin Prescription or no y be administered ler of a person aut gs. Medications shall ents only when aut ent's physician. Medications shall ent's physician. Medications shall ents only when aut ent's physician. Medications shall ent's name instructions for ac o date and time the	DEFICIENCIES   (X1) PROVIDER/SUPPLIER/CLIA     DER OR SUPPLIER   MHL078-159     Y RESIDENTIAL SERVICES   220 C     SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     TIAL COMMENTS   Somplaint and follow up survey survey was mpleted on November 12, 2021. The mplaint was substantiated (Intake C00180485). Deficiencies were cited.     is facility is licensed for the following service regory: 10A NCAC 27G .1700 Residential eatment Staff Secure for Children or olescents.     G .0209 (C) Medication Requirements     ANCAC 27G .0209 MEDICATION QUIREMENTS     Medication administration: Prescription or non-prescription drugs shall y be administered to a client on the written ler of a person authorized by law to prescribe igs.     Medications shall be self-administered by ents only when authorized in writing by the ent's physician.     Medications shall be self-administered by ents only by licensed persons, or by icensed persons trained by a registered nurse, armacist or other legally qualified person and vileged to prepare and administer medications. A Medication Administration Record (MAR) of drugs administered to each client must be kept rent. Medications administered shall be corded immediately after administration. The trais to include the following: client's name; name, strength, and quantity of the drug; of the and time the drug is administering the drug; name or initials of person administering the drug;	DEFICIENCIES   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CA     DRRECTION   MHL078-159   B. WING     DER OR SUPPLIER   STREET ADDRESS, CITY, STATE     Y RESIDENTIAL SERVICES   220 CALVINS ROAD     SUMMARY STATEMENT OF DEFICIENCIES   ID     (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX     REGULATORY OR LSC IDENTIFYING INFORMATION)   Y 000     TIAL COMMENTS   V 000     complaint and follow up survey survey was   PREFIX     mplaint was substantiated (Intake   V 000     CO180445). Deficiencies were cited.   is facility is licensed for the following service     egory: 10A NCAC 27G .1700 Residential   atament Staff Secure for Children or     olescents.   V 118     G .0209 (C) Medication Requirements   V 118     A NCAC 27G .0209 MEDICATION   Yull     QUIREMENTS   Medication administration:     Prescription or non-prescription drugs shall   y be administered to a client on the written     ler of a person authorized by law to prescribe   gs.     Medications shall be self-administered by   ants only when authorized in writing by the     entis bylysician.   Medications administering the drug;     neaded to prepare	EFFICIENCIES   [N1] PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:   (P2) MULTIPLE CONSTRUCTION A BUILDING:     MHL07B-159   B. WING     DER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE     Y RESIDENTIAL SERVICES   220 CALVINS ROAD SHANNON, NC 28386     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDERSUPPLIER     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDERSUPPLIER     SOMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILL COMMENTS   ID PREFIX TAG   PROVIDERSUPPLIER     Somplaint and follow up survey survey was mpleted on November 12, 2021. The mplaint was substantiated (Intake CO0180485). Deficiencies were cited.   V 000     SG 0209 (C) Medication Requirements   V 118     A NCAC 27G .0209 MEDICATION QUIREMENTS   V 118     Medication administration: Prescription or non-prescription drugs shall by be administered to a client on the written ler of a person authorized by law to prescribe igs.   Notal be self-administered by ents only when authorized in writing by the ministered on blay bicensed persons, or by icensed persons trained by a registered nurse, armacist or other legally qualified person and vileged to prepare and administer efficience.   Administer administer efficience.     R is to including injections, shall be enrice trank admininistered son a	DEFICIENCICIS (N) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (P2) MULTIPLE CONSTRUCTION A BUILDING (P3) DATA A BUILDING   MHL078-159 B. WING 11   DEFICIENTIAL SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE   Y RESIDENTIAL SERVICES Z20 CALVINS ROAD SHANNON, NC 28386   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ADTON BIOLID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (RISE DESTIFYING INFORMATION)   TIAL COMMENTS V 000   TIAL COMMENTS V 000   omplaint and follow up survey survey was mpleted on November 12, 2021. The mplaint was substantiated (Intake CO0180485). Deficiencies were cited. V 118   S JO209 (C) Medication Requirements V 118   A NCAC 27G. 0209 MEDICATION OULFREMENTS Medications shall be self-administered by ents only when authorized by law to prescribe gs. V 118   Medication administered to a client on the written infs physician. Medications administered only by the ministered on y registered nurse, armacist or other legally qualified person and uigeed to prepare and administer medications. A Medications administered shall be orded immediately after administered intors. A Medication administered shall be orded immediately after administered; and name, strength, and quantils of the drug; instructions for administering

SHANNON, NC 28386   (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPL	STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	SURVEY
B28 CALVINS ROD SHANNON, NC 2338       OWNOR ANY STATEMENT OF DEFICIENCES RECOVER OF CONTRACT STATEMENT OF DEFICIENCES V118     PROVIDENTS PLAN OF CORRECTION RECOVER OF CONTRACT STATEMENT OF DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT OF DEFICIENCES DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT OF DEFICIENCES DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT OF DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT OF DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     OPEN RECOVER OF CONTRACT STATEMENT DEFICIENCY     DEFICIENCY     DEFICIENCY       V118     This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARS current affecting three of three audited clients (#2, #3 and #5). The findings are: . 2 year old male: . 4 Admission date of 06/24/21. . Diagnoses of Attemtion Deficient M2's record revealed: . 2 year old male: . 4 Admission date of 06/24/21. . Diagnoses of Attemtion Deficient M2's September 2021 MAR revealed the following medications were initialed by state and aministered on			MHL078-159	B. WING			
SHANNON, NC 28386       (M) ID TAC     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCED BY FULL TAG     ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCED BY FULL (EACH DEFICIENCE) DEFICIENCE (EACH DEFICIENCE) (EACH DEFICIENCE) DEFICIENCE (EACH DEFICIENCE) (EACH DEFICIENCE (EACH DEFICIENCE) (EACH DEFICIENCE (EACH DEFICIENCE) (EACH DEFICIENCE (EACH DEFICIENC	NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SHANNON, NC 28386       PRETX TAG     SUMMARY STATEMENT OF DEFICIENCES (EACH ORDER) PLAN OF CORRECTION (EACH ORD	BETTER	WAY RESIDENTIAL SE	RVICES				
PREFIX TAG   (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATORY OR US. DENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   Continued From page 1   V 118     V118   Continued From page 1   V 118   V 118   V     This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of three audited clients (#2, #3 and #5). The findings are:   A. Review on 11/10/21 of client #2's record revealed: - 12 year ofd male. - Admission date of 06/24/21. - Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD). Adjustment Disorder with Mood Disturbance of Emotions and Conduct Other Specified Trauma and Stressor related disorder.   Review on 11/10/21 of client #2's September 2021 MAR revealed the following medications were initialed by staff as administered on 09/31/21 (30 days in the month of September): - Uthing (treats seizures).   Here audited the of the seizures).     During interview on 11/10/21 client #2 revealed   During interview on 11/10/21 client #2 revealed   Here audited the seizures).			SHANNO	ON, NC 28386			
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: Based on record review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of three audited clients (#2, #3 and #5). The findings are: A. Review on 11/10/21 of client #2's record revealed: - 12 year old male. - Admission date of 06/24/21. - Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Adjustment Disorder with Mood Disturbance of Emotions and Conduct Other Specified Trauma and Stressor related disorder. Review on 11/10/21 of client #2's September 2021 MAR revealed the following medications were initilated by staff as administered on 09/31/21 (30 days in the month of September): - Lithium (treats Bipolar Disorder). - Oxcarbazepine (treats seizures). During interview on 11/10/21 client #2 revealed	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
file followed up by appointment or consultation with a physician.	V 118	Continued From page	e 1	V 118			
Based on record review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of three audited clients (#2, #3 and #5). The findings are:     A. Review on 11/10/21 of client #2's record revealed: - 12 year old male. - Admission date of 06/24/21. - Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Adjustment Disorder with Mood Disturbance of Emotions and Conduct Other Specified Trauma and Stressor related disorder.     Review on 11/10/21 of client #2's September 2021 MAR revealed the following medications were initialed by staff as administered on 09/31/21 (30 days in the month of September): - Lithium (treats Bipolar Disorder). - Oxcarbazepine (treats seizures).     During interview on 11/10/21 client #2 revealed		file followed up by ap					
revealed: - 12 year old male. - Admission date of 06/24/21. - Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Adjustment Disorder with Mood Disturbance of Emotions and Conduct Other Specified Trauma and Stressor related disorder. Review on 11/10/21 of client #2's September 2021 MAR revealed the following medications were initialed by staff as administered on 09/31/21 (30 days in the month of September): - Lithium (treats Bipolar Disorder). - Oxcarbazepine (treats seizures). During interview on 11/10/21 client #2 revealed		Based on record revie interview, the facility to medications on the w and failed to keep the three of three audited	ew, observation and failed to administer ritten order of a physician MARs current affecting				
B. Review on 11/10/21 of client #3's record		revealed: - 12 year old male. - Admission date of 0 - Diagnoses of Attent Disorder (ADHD), Ad Disturbance of Emoti Specified Trauma and Review on 11/10/21 of 2021 MAR revealed t were initialed by staff 09/31/21 (30 days in - Lithium (treats Bipol - Oxcarbazepine (treat During interview on 1 he received his media	6/24/21. ion Deficit Hyperactivity justment Disorder with Mood ons and Conduct Other d Stressor related disorder. of client #2's September the following medications as administered on the month of September): lar Disorder). ats seizures). 1/10/21 client #2 revealed cation daily.				

Division of Health Service Regulation STATE FORM

6899

L6VV11

If continuation sheet 2 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED R		
			A. BUILDING:				
		MHL078-159	B. WING		11/12/2021		
AME OF PI	ROVIDER OR SUPPLIER	STREET	EET ADDRESS, CITY, STATE, ZIP CODE				
BETTER	R WAY RESIDENTIAL SE	RVICES	VINS ROAD				
		SHANN	ON, NC 28386				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
V 118	Continued From pag	e 2	V 118				
	- Admission date of 02/23/21. - Diagnoses of ADHD and Intermittent Explosive Disorder.						
	2021 MAR revealed were initialed by staf	the month of September): /chotic).					
	During interview on 11/10/21 client #3 revealed he received his medication daily.						
	C. Review on 11/10/2 revealed: - 12 year old male. - Admission date of ( - Diagnoses ADHD ( Disruptive Mood Dys	Combined Type and					
	2021 MAR revealed were initialed by staf 09/31/21(30 days in - Adderal (treats AD - Prozac (antidepress - Risperidone (antips - Hydroxyzine (treats	the month of September): HD). sant). sychotic).					
	During interview on 7 he received his medi	11/10/21 client #5 revealed ication daily.					
		1 the Licensee stated she ed to be kept current.					
	Due to the failure to a medication administr	accurately document ation it could not be					

STATE FORM

L6VV11

If continuation sheet 3 of 8

	OF DEFICIENCIES	Ilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL078-159	B. WING		11	R / <b>12/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
DETTER		220 CAL	VINS ROAD			
ABEITER	R WAY RESIDENTIAL SE	SHANN	ON, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pag	e 3	V 118			
	determined if clients as ordered by the ph	received their medications ysician.				
		been cited 7 times since the /18 and must be corrected				
V 121	27G .0209 (F) Medic	ation Requirements	V 121			
	governing body or op for obtaining a review regimen at least even shall be to be perform physician. The on-sit the client's physician the review when mee (2) The findings of th	r: res psychotropic drugs, the perator shall be responsible v of each client's drug ry six months. The review ned by a pharmacist or e manager shall assure that is informed of the results of dical intervention is indicated. e drug regimen review shall ient record along with				
	facility failed to obtain one of three audited psychotropic drugs.	ews and interview, the n drug regimen reviews for clients (#3) who received				
	-	02/23/21. tion Deficit Hyperactivity ttent Explosive Disorder.				

	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING: B. WING		СОМ	E SURVEY PLETED
		MHL078-159			11	/12/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
A BETTER	R WAY RESIDENTIAL SE	RVICES	ON, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 121	Continued From page	e 4	V 121			
		gimen review performed by				
	regimen revealed: - Zoloft (treats Depresonce daily. - Oxcarbazepine (treat tablet in morning a 3 - Melatonin (sleep aid bedtime. - Seroquel (antipsych one-half tablet at bed - Lithium (treats Mani tablet at bedtime. Interview 11/10/21 the aware 6 month drug n required for clients th medications	d) 5mg - one tablet at notic) 100mg - one and ltime. ic Depression) 150mg - one e Licensee stated she was regimen reviews were at received psychotropic itutes a re-cited deficiency				
V 521	10A NCAC 27E .0104 PHYSICAL RESTRATIME-OUT AND PRO FOR BEHAVIORAL C (e) Within a facility w may be used, the pol in accordance with th (9) Whenever a restri	AINT AND ISOLATION DTECTIVE DEVICES USED CONTROL where restrictive interventions icy and procedures shall be the following provisions: ictive intervention is utilized, be made in the client record hum: ent's physical and eing;	V 521			

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
					R	
		MHL078-159	B. WING		11	/12/2021
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BETTER	R WAY RESIDENTIAL SE	RVICES	LVINS ROAD ON, NC 28386			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET DATE
V 521	Continued From page	e 5	V 521			
	duration of the behav	ior which led to the				
	-	precipitating circumstance				
	contributing to the on					
		he use of the intervention,				
		estrictive interventions				
	considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date,					
	time and duration of i	-				
	(E) a description of accompanying positive					
	methods of intervention;					
	(F) a description of the debriefing and planning					
	with the client and the legally responsible person,					
	if applicable, for the emergency use of seclusion,					
	physical restraint or isolation time-out to eliminate					
	or reduce the probability of the future use of restrictive interventions;					
		ne debriefing and planning				
		e legally responsible person,				
	if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if					
	determined to be clin	ically necessary; and				
	( ) 0	e of the facility employee				
		the employee who further				
	authorized, the use o	t the intervention.				
	This Rule is not met					
		ews and interviews, the				
	facility failed to ensur	-				
		n the client record when a				
	of three clients (#1).	n was utilized affecting one The findings are:				
		of client #2's record revealed:				
	- 12 year old male.					
	- Admission date of 0					
	-	ion Deficit Hyperactivity				
	Disorder, Adjustment	Disorder with Mood				

Division of Health Ser STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		COMF	SURVEY
		MHL078-159	B. WING		R / <b>12/2021</b>	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
A BETTER	WAY RESIDENTIAL SE	RVICES	VINS ROAD DN, NC 28386			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG	(	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
V 521	Continued From page	e 6	V 521			
		ons and Conduct Other d Stressor related disorder.				
	Revie won 11/10/21 c client #2 revealed: - Date of Incident: 11/	of a facility incident report for				
	- Time of incident: 11: - "Describe the cause	:00am. of the incidentmember				
	doing them right seve back to his room cuss	rewrite a paper, after not eral times. [Client #2] walked sing and slammed his door.				
	the door closed on st	the door and [Client #2] held aff. [Client #2] threatened to swear. [Client #2] started				
	hitting things and thro staff stepped out. [Cli	owing things in his room as				
	quickly released him appeared calm."	after he was talked to, and f required information when				
		on was implemented on				
	Interview on 11/10/21 - A restrictive interver	the Licensee stated: ntion detail report had not				
	11/07/21 with client #					
		restrictive intervention umentation when utilized.				
	This deficiency consti and must be correcte	itutes a re-cited deficiency d within 30 days.				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 EXTERIOR REQUIR					
	(c) Each facility and it					

Division of Health Service Regulation STATE FORM

6899

L6VV11

If continuation sheet 7 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL078-159	B. WING			R / <b>12/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
A BETTER	R WAY RESIDENTIAL SE	RVICES	VINS ROAD DN, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From page	e 7	V 736			
	manner and shall be odor.	kept free from offensive				
	ceiling and was loose switch had a hole in t rust stains on the surf - Client #2's room had wall. The wall had an foot section of unpain was cracked. - The hallway had pai door and a rusty ceilin -Client #2's bedroom away from the sub flo	om had a rusty vent in the a. The wall near the light he sheetrock. The sink had face. d a golf ball sized hole in the approximately 2 foot by 2 sted repair. The light switch int peeled away from the ng vent. the flooring was peeling yor. yay had a bubbled area near				
		1/10/21 the Licensee stated of the repairs needed in the				