

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL033-051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETTER DAYS AHEAD INC #4</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SOUTH GLENDALE AVENUE ROCKY MOUNT, NC 27801</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was attempted on September 7, 2023. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was 2/1/2023.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>During interview on 9/7/23 the Licensee reported: - the client was discharged to a sister facility</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_