				_ETED		
			R			
MHL033-029	B. WING		09/1	09/19/2023		
STREET ADI	ORESS, CITY, S	STATE, ZIP CODE				
BETTER DAYS AHEAD, INC #2 1212 HILL STREET ROCKY MOUNT. NC 27801						
SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETE DATE		
	V 000					
census of 2. The survey sample consisted of audits of 2 current clients. 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						
The contract of the contract o	AMEDICATION Stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by a registered nurse, egally qualified person and and administer medications. Instration Record (MAR) of the to each client must be kept administered shall be a fellowing: n-d quantity of the drug; ministering the drug;	STREET ADDRESS, CITY, S 1212 HILL STREET ROCKY MOUNT, NC 2 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) UP SURVEY WAS COMPleted es were cited. If for the following service: OC Supervised Living for ental Disability. If for 3 and currently has a ey sample consisted of ents. Ation Requirements W 118 WEDICATION Stration: In-prescription drugs shall to a client on the written inorized by law to prescribe The self-administered by inorized in writing by the Iding injections, shall be icensed persons, or by ained by a registered nurse, regally qualified person and and administer medications. Inistration Record (MAR) of If to each client must be kept administered shall be after administration. The following: Ind quantity of the drug; ministering the drug; drug is administered; and	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 HILL STREET ROCKY MOUNT, NC 27801 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL UDENTIFYING INFORMATION) WE SURVEY WAS COMPleted es were cited. If for the following service: IC Supervised Living for ental Disability. If for 3 and currently has a ey sample consisted of ents. Atton Requirements V 118 IMAGE OF THE ADDRESS, CITY, STATE, ZIP CODE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY) V 000 WP SURVEY WAS COMPLETED TO THE APPROVIDENCY V 118 IMAGE OF THE APPROVIDENCY V 118 V 118 IMAGE OF THE APPROVIDENCY V 118 IMAGE OF THE APPROVIDENCY V 118 IMAGE OF THE APPROVIDENCY V 118 V 118 IMAGE OF THE APPROVIDENCY V 118 IMAGE OF THE APPROVIDENCY (EACH CORRECTIVE ACTION A	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 HILL STREET ROCKY MOUNT, NC 27801 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) WE survey was completed es were cited. If for the following service: IC Supervised Living for ental Disability. If or 3 and currently has a ey sample consisted of ental. Ation Requirements WEDICATION Stration: In-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the dding injections, shall be icensed persons, or by ained by a registered nurse, gally qualified person and and administer medications. Inistration Record (MAR) of a to each client must be kept administered shall be after administered shall be after administration. The following: Ind quantity of the drug; ministering the drug; drug is administering d, and		

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

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL033-029	B. WING R 09/19		R 9/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE			
BETTER	BETTER DAYS AHEAD, INC #2 1212 HILL STREET POOLS MOUNT NO 67884						
	T	RUCKY	MOUNT, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 1	V 118				
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation					
	failed to administered order of a physician current for 1 of 1 click Review on 9/6/23 of a dmitted and admitted and admitted aphysician order 50mg (milligram) the	view and interview the facility ed medication on the written a & failed to keep MARs ent (#1). The findings are: If client #1's record revealed: Lutism, Intellectual ability & Hypertension er dated: Chlorpromazine ree times a day (8am, 2pm & s) & Quetiapine 400mg					
	Review on 9/6/23 of 2023 & September - Chlorpromazine & 8pm from 9/1/23 - Quetiapine - no	f client #1's July 2023, August 2023 MAR revealed: was not documented at 2pm					
	bin revealed: - 3:02pm: no Que	fice Assistant picked up					

Division of Health Service Regulation

STATE FORM 6899 HQZS11 If continuation sheet 2 of 4

Division of Health Service Regulation							
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
					R		
		MHL033-029	B. WING			9/2023	
NAME OF I	PROVIDER OR SUPPLIER	CTDEET AD	DDESS CITY S	STATE, ZIP CODE			
INAIVIL OI I	-NOVIDEN ON SUFFEIEN			STATE, ZIF CODE			
BETTER	DAYS AHEAD, INC #2	2	STREET	27904			
			IOUNT, NC				
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG	`	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE	
				DEFICIENCY)			
V 118	Continued From page 2		V 118				
	During interview on	9/6/23 staff #1 reported:					
	 worked at the fa 	acility on Wednesday and					
	Thursday						
		ran out sometime in August					
	2023						
		y it was not refilled e the full time staff called the					
		orior to medications running					
	out	mor to medications running					
		2023 MAR for the Quetiapine					
	was an oversight w						
		9/6/23 the pharmacy					
	technician reported						
	-	was filled 7/31/23 & not filled					
	again until 9/6/23	bluming of a fact will a in					
	- client #1 probal August 2023	bly missed a few pills in					
		notes why the Quetianine was					
	- there were no notes why the Quetiapine was not filled until 9/6/23						
	During interview on	9/6/23 the Office Assistant					
	reported:						
		t run out of his Quetiapine					
	· · · · · · · · · · · · · · · · · · ·	he medication today					
		rt time and was not aware					
	client #1 ala not mis	ss the dose of Quetiapine					
	During interview on	9/6/23 the Licensee reported:					
		osed to contact the pharmacy					
	5 days prior to med						
		d MARs for missing initials					
		rofessional will review missing					
		medications running out at the					
	next staff meeting						
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736				
	10A NCAC 27G .03	03 LOCATION AND					

Division of Health Service Regulation STATE FORM

HQZS11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		MHL033-029	B. WING		1	9/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRE				STATE, ZIP CODE		
BETTER	BETTER DAYS AHEAD, INC #2 1212 HILL STREET ROCKY MOUNT, NC 27801					
(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 736	Continued From pa	ge 3	V 736			
V 736	EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor. This Rule is not me Based on observati was not maintained manner. The finding Observation and to 1:51pm revealed: Living room- pa warped from water 3 piece living ro cracked, peeling & the love seat comiddle During interview sta the client #1 "pi the love seat During interview on would have ma	REMENTS It its grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: ion and interview, the facility I in a safe, attractive & orderly gs are: ur of the facility on 9/6/23 at anel near window appeared damaged bom couch set fabric was faded ushion was sunken in the	V 736			
	was not aware the i	eviously been repaired but she issue still exited the living room set				
	This deficiency con and must be correct	stitutes a re-cited deficiency sted within 30 days.				

6899

Division of Health Service Regulation STATE FORM

HQZS11 If continuation sheet 4 of 4