STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033032	A. BUILDING: _____ B. WING _____	R 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS AHEAD OF ROCKY MOUNT, INC	1713 KINGS CIRCLE DRIVE ROCKY MOUNT, NC 27801

(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 9/19/23. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 748	27G .0304(b)(2) Fire Retardant Mattresses 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (2) All mattresses purchased for existing or new facilities shall be fire retardant. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure it was equipped in a manner that ensured the physical safety of 1 of 3 audited clients (#3). The findings are: Observation on 9/7/23 at 1:13pm of client #3's bedroom revealed: - the mattress was sunk in the middle During interview on 9/13/23 the office assistant	V 748	DHSR - Mental Health OCT 12 2023 Lic. & Cert. Section Client #3 mattress will be replaced by 10-13-2023. The Group home staff is responsible for reporting any abnormalities; both interior and exterior to the Qualified Professional. Qualified Professional will monitor the interior and exterior of the facility quarterly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Director of Administration — TITLE — (X6) DATE: 10/4/2023
STATE FORM 6899 XUL411 If continuation sheet 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 748	Continued From page 1 reported: - was not aware the mattress was like that - mattress had not long been purchased During interview on 9/19/23 the Licensee reported: - the mattress will be replaced	V 748	Client #3 mattress will be replaced by 10-13-2023. The Group home staff is responsible for reporting any abnormalities both interior and exterior to the Qualified Professional. Qualified Professional will monitor the interior and exterior of the facility quarterly.	