Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: ________ B. WING ________	R-C **09/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY RESIDENTIAL SERVICES	**220 CALVINS ROAD SHANNON, NC 28386**

(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 A complaint and follow up survey was completed on September 11, 2024. One complaint was substantiated (NC00221371) and one complaint was unsubstantiated (NC00221614). Deficiences were cited. The faciity is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children Or Adolescents. The facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients. This survey originally closed on September 5, 2024 but was reopened on September 10, 2024 due to additional complaints.	V 000		
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other	V 300		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: ______ B. WING ______	R-C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY RESIDENTIAL SERVICES	220 CALVINS ROAD SHANNON, NC 28386

(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 300	Continued From page 1 representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide advance written notification of a clients discharge to the treatment team and the legally responsible person, and failed to ensure a service planning meeting was held within five business days of an emergency discharge affecting 1 of 3 former clients (FC#5). The findings are: Review on 9/4/24 of FC #5's record revealed: -13 year old male. -Admitted on 8/16/24. -Discharged on 8/29/24. -Diagnoses of Attention Deficit Hyperactivity Disorder combined presentation and Oppositional Defiant Disorder. -No documentation of a service planning meeting	V 300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: ______ B. WING ______	R-C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY RESIDENTIAL SERVICES	220 CALVINS ROAD SHANNON, NC 28386

(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 300	Continued From page 2	V 300		

within 5 days of his discharge on 8/29/24.

Review on 9/5/24 of an incomplete discharge summary for FC #5 dated 8/29/24 revealed:
-"Reason for discharge: Consumer is physically aggressive toward staff. Consumer has been AWOL (Absent without leave) twice. Property destruction by throwing a brush and breaking the window out in his room...."

Interview on 9/5/24 FC #5's guardian representative revealed:
-She received a call on 8/28/24 from the Assistant Program Director stating FC #5 would be discharged the following day.
-She was informed she would receive a discharge summary at discharge.
-She had not received any written advance notice of discharge and discharge had not been discussed.
-There was no service planning meeting for FC #5.
-The facility had not provided any clinical recommendations for FC #5.
-FC #5 was admitted to another facility at the same level of care.

Interview on 9/4/24 FC #5 Care Manager stated:
-The facility discharged FC #5 and would not have an emergency child and family team meeting or give a clinical recommendation.
-She attempted to get the facility to make a plan for FC #5 but they were not willing to.
-She requested the facility give a 10 day health and safety notice but the facility declined.
-FC #5 "wasn't in crisis in her opinion" when he was discharged.

Interview on 9/4/24 the Program Director stated:
-The facility had not provided a discharge notice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: ____ B. WING ____	R-C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY RESIDENTIAL SERVICES	220 CALVINS ROAD SHANNON, NC 28386

(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 300	Continued From page 3 to FC #5's guardian or case manager. -It was not her "typical" procedure to discharge a client without a written notice. -FC #5 was discharged without notice due to his elopement behaviors and she felt like the facility could not keep him safe. FC #5 was in an area that he was not familiar with and had eloped. -She was not aware a service planning meeting needed to be held	V 300		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 9/4/24 between 11:35am-11:45am during a tour of the facility revealed: -A paint patch approximately 12 inches was on wall in the first vacant bedroom #1. -A 12 inch piece of wood was missing from the corner of bedroom door. -A broken window with a softball size hole with shards of glass inside the bottom of the window pane. -A dresser with 4 broken drawers. The shorter drawer had an approximate 2 inch space between the third and fourth drawer. -There was gray residue on the vent in the front hallway across from vacant bedroom #1.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: ______ B. WING ______	R-C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY RESIDENTIAL SERVICES	**220 CALVINS ROAD SHANNON, NC 28386**

(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 736	Continued From page 4 -There was a brownish orange residue, along with a gray residue on the air vent in the first bathroom in the front hallway. The air vent was loosely affixed from the ceiling. -There was paint peeling consistently from the wall approximately 20 inches in diameter in the second bathroom on short hallway. -There was an brownish orange residue, along with a gray residue on the air vent. The air vent was loosely affixed from wall. -The vanity was separated from wall approximately 2 inches on the left side and there were missing screws. There was a 1 inch space at the top of the doors to vanity. -There was paint peeling from the wall in 3 areas under the cabinets of kitchen that were approximately 1 inch in diameter. -The cabinet was separated from wall approximately 1 inch. Interview on 9/4/24 the Assistant Program Director stated: -The broken window in the first vacant bedroom had a work order submitted to be repaired. Interview on 9/4/24 the Program Director stated: -The additonal repairs in the other areas will be addressed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		