PRINTED: 12/16/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MUI 076 146	B. WING		42/4			
		MHL076-145	B. W. C		12/1	2/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
A BETTE	A BETTER PATH, INC 2106 NEWELL STREET RAMSEUR, NC 27316							
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
V 000	V 000 INITIAL COMMENTS		V 000					
	The complaint was	was completed on 12/12/24. unsubstantiated (intake leficiency was cited.						
		sed for the following service C 27G .1700 Residential cure for Children or						
	census of 3. The su	sed for 3 and has a current urvey sample consisted of client and 1 former client.						
V 298	27G .1706 Residential Tx. Child/Adol - Operations		V 298					
	(a) Each facility share of 12 children and a (b) Family member persons shall be invited in order to assure a restrictive setting. (c) The residential shall coordinate with to ensure that the comet as identified in the treatment plantable to attend schoold coordinate services alternative learning job placement. (d) Psychiatric contended for each check (e) If an adolescen receiving treatment for six months or unyear, whichever is less that the contended for each check the check the contended for each check the check the contended for each check the chec	rs or other legally responsible volved in development of plans smooth transition to a less treatment staff secure facility the the local education agency hild's educational needs are the child's education plan and Most of the children will be ol; for others, the facility will across settings such as programs, day treatment, or a sultation shall be available as ild or adolescent. It has his 18th birthday while in the facility, he may remain till the end of the state fiscal						

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			С	
		MHL076-145	B. WING			12/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
A BETTE	ER PATH, INC		/ELL STREE R, NC 27316				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 298	entitlement is count plan. (g) Each facility sh	rsonal belongings unless such ter-indicated in the treatment all operate 24 hours per day, ek, and each day of the year.	V 298				
	facility allowed a cli excess of the maximonths following cl of the state fiscal ye	et as evidenced by: view and interviews, the ent to remain in the facility in mum allowed time of six ients 18 th birthday or until end ear affecting one of one nt (#1). The findings are:					
	-Readmission date -Diagnoses of Disru Disorder and Post- -She was 18 years 11/21/24. -She was under the	uptive Mood Dysregulation Traumatic Stress Disorder. old when readmitted on e guardianship of the ial Services (DSS) in her home					
	-She returned to the -She was discharge 2024She was discharge independent living the Interviews on 12/11 Qualified Professio -Client #1 was disc	24 with client #1 revealed: e facility in November 2024. ed from the facility in October ed because she went to an facility when she turned 18. /24 and 12/12/24 with the nal revealed: harged from the facility in returned in November 2024.					

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If continuation sheet 3 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DAT COM		(X3) DATE COMP	TE SURVEY MPLETED	
		MHL076-145	B. WING		12/1	2/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
A BETTE	ER PATH, INC		/ELL STREE R, NC 27316				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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)	LD BE	(X5) COMPLETE DATE	
V 298	-While client #1 was mother's house in C she could not return home county Depar (DSS) guardianClient #1's DSS guardianClient #1's DSS guardianClient #1's mother careClient #1's mother 2024 and asked if sarahey were still provident #1 even though facility prior to her in 2024She thought it was	ge 2 s on therapeutic leave at her October 2024, she was told in to a Better Path, Inc. by her the theoretic form the facility because repaying for her treatment and and sister called in November the could return to the facility. Viding outpatient services for gh she no longer lived at the moving back in November ok for client #1 to move back in though she was 18.	V 298				

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