

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL033-035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/07/2025
NAME OF PROVIDER OR SUPPLIER BETTER DAYS AHEAD OF ROCKY MOUNT #3		STREET ADDRESS, CITY, STATE, ZIP CODE 829 LONG AVENUE 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 5/7/25. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
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 an attractive and orderly manner. The findings are: Observation on 5/2/25 at approximately 9:12am revealed: Kitchen: - knobs were missing from 4 of 13 cabinet doors - knobs were missing from 2 of 4 drawers - there was a four inch portion of a tile peeling up at one corner on the floor in front of the sink Client #3's bedroom: - dresser had 2 drawers missing with clothes piled in the open space - 2 of 4 remaining drawers did not close	V 736		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL033-035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/07/2025
NAME OF PROVIDER OR SUPPLIER BETTER DAYS AHEAD OF ROCKY MOUNT #3		STREET ADDRESS, CITY, STATE, ZIP CODE 829 LONG AVENUE 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 736	<p>Continued From page 1</p> <p>properly and clothes were coming out underneath the bottom drawer</p> <p>Interview on 5/2/25 client #3 reported:</p> <ul style="list-style-type: none"> - he went to pull on the dresser drawer one day and it broke - it had been years since it broke - thought he told staff but knew staff had seen it and knew about it - the Qualified Professional (QP) said something a few weeks prior about replacing it <p>Interview on 5/2/25 staff #1 reported:</p> <ul style="list-style-type: none"> - the knobs came off because the screws came loose when client #1 played with them - did not remember when this first occurred but it was an ongoing problem - thought the floor tile coming up was because "the clients drag their feet" - did not remember when she had first noticed it - "I don't know when I discussed it" with QP or "when they are coming to replace it" - client #3 had not requested a new dresser - they had tried to repair the dresser a multiple times but it broke again - did not specify when the dresser had first broken or when it was repaired <p>Interview on 5/2/25 the QP reported:</p> <ul style="list-style-type: none"> - visited the facility at least once a month - the House Manager reported to him each week about any needs - client #3 broke his dresser "recently" but did not specify when - client #3 "tears stuff up" and they had already replaced a bed for him when he had broken the frame <p>This deficiency constitutes a re-cited deficiency</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL033-035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/07/2025
NAME OF PROVIDER OR SUPPLIER BETTER DAYS AHEAD OF ROCKY MOUNT #3			STREET ADDRESS, CITY, STATE, ZIP CODE 829 LONG AVENUE 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 736	Continued From page 2 and must be corrected within 30 days.	V 736			