		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL033-139	B. WING		05/	07/2025
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ETTER	DAYS AHEAD OF RC	ICKY MOUNT INC	LPHIA DRIVE MOUNT, NC 2	7801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey w Deficiencies were c	vas completed on 5/7/25. sited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
		sed for 3 and has a current urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	<ul> <li>only be administered order of a person a drugs.</li> <li>(2) Medications shat clients only when a client's physician.</li> <li>(3) Medications, included administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication recorded immediate MAR is to include the (A) client's name;</li> <li>(B) name, strength,</li> <li>(C) instructions for</li> <li>(D) date and time the distribution of a person of the strength of the stren</li></ul>	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications dministration Record (MAR) of red to each client must be kep is administered shall be ely after administration. The				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		MHL033-139	B. WING		05/	07/2025
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ETTER	DAYS AHEAD OF RO	DCKY MOUNT INC		7904		
(X4) ID	SUMMARY ST		MOUNT, NC 2	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLE DATE
V 118	Continued From page 1		V 118			
	checks shall be rec	for medication changes or corded and kept with the MAR appointment or consultation				
	Based on observat interview the facility	et as evidenced by: ion, record review, and / failed to ensure medications as prescribed for 1 of 3 clients are:				
	<ul> <li>admitted 5/13/9</li> <li>diagnoses: Mile</li> <li>Adjustment Disorder</li> <li>Disorder, Insomnia</li> <li>FL2 signed by</li> </ul>	d Mental Retardation, er with Anxiety, Schizoaffective doctor dated 10/14/24: ) milligrams (mg) 2 times daily'				
	<ul> <li>Olanzapine 10</li> <li>twice daily</li> <li>documented as</li> </ul>	of client #3's MARs revealed: mg Take 1 tablet by mouth s administered twice daily nonths of February, March, and				
	of client #3's medic - blister pack wit - tablets had ma 0165 on the other - 6 pills missing	9/25 at approximately 3:45pm cations revealed: h white oval shaped tablets rkings of 7.5 on one side and from blister pack I: Olanzapine 7.5 mg Take one				

STATE FORM

If continuation sheet 2 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL033-139	B. WING		05/	07/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
BETTER	DAYS AHEAD OF RC		LPHIA DRIVE MOUNT, NC 2	7801		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 118	Continued From pa	ige 2	V 118			
	tablet by mouth twi	ce daily				
	Interview on 4/29/2	5 the Director of				
	Administration repo					
	<ul> <li>the pharmacy dispensed the incorrect dose</li> <li>staff was supposed to check the doses on the</li> </ul>		9			
	medications when they arrived at the facility					
	- she would talk with the staff about double-checking all the medications when they					
	arrived					
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a saf	803 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and orderly e kept free from offensive				
	was not maintained	et as evidenced by: ion and interview, the facility I in a safe, clean, attractive r and free from offensive odor.				
	Observation on 4/2 revealed:	9/25 at approximately 11am				
	fixture on ceiling - multiple empty floor throughout the - dirty clothes we	lbs were missing from the light potato chip bags were on the				
	substance, a clear	cans, a black mug with a browr glass with a clear liquid, and otato chip bags were on the	n l			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL033-139	B. WING		05/	07/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • •		
BETTER	DAYS AHEAD OF RO	CKY MOUNT INC	LPHIA DRIVE MOUNT, NC 2	7801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE	
iAo		,		DEFICIENC			
V 736	Continued From page 3		V 736				
	nightstand						
	Client #2's bedroom: - 2 out of 4 light bulbs were not working in the light fixture on the ceiling - had a urine smell						
	Client #3's bedroom: - 3 out of 4 light bulbs were missing from the light fixture on the ceiling fan						
	Client bathroom: - 1 out of 3 lights bulbs were not working on the light fixture above the sink						
	Kitchen: - there were two storage door	long circular cracks in the					
	dusty residue - there was an ol	it was covered with dark gray d doorbell panel on the wall n inside wires exposed					
	encouragement did - laundry was do - if the clients' clo often, she washed s	like to clean his room and n't always work ne weekly for each client othes needed washed more	5				
	reported: - visited the facili - the House Man week about any new	the Qualified Professional ty at least once a month ager reported to him each eds e for ensuring facility was					

STATE FORM

Y8EK11

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		05/07/0	
		MHL033-139			05/	07/2025
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> LPHIA DRIVE	TATE, ZIP CODE		
BETTER	DAYS AHEAD OF RO	DCKY MOUNT INC	MOUNT, NC 2	7801		
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V 736	Continued From pa	age 4	V 736			
	depending on clien - would ensure a immediately Interview on 4/29/2 Administration repor- - client #1 never - client #1 knock kitchen storage abo - he destroyed th	all issues were addressed 5 the Director of orted: wanted to clean his room ted a hole in the door to the out a week ago hings when he got mad staff washed soiled clothes and	4			
	ealth Service Regulation					

Y8EK11