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
	MHL064-075	A. BUILDING: _____ B. WING _____	R 03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BTW HOME CARE SERVICES	2709 GARY ROAD ROCKY MOUNT, NC 27803

(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 03/23/18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR-Mental Health APR 25 2018 Lic. & Cert. Section	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan All Consumers not attending PSR programs or where BTW has opted to complete PCP's for consumers in PSR programs will have electronic and paper calendar dates as to when PCP's are due. The QP and the licensees for each facility will coordinate due dates to ensure PCP's are completed on time and current for all consumers. The QP and the licensees will verify on a monthly basis that any PCP's that are due will be completed.	04/05/18

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 4-15-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-075	A. BUILDING: _____ B. WING _____	R 03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BTW HOME CARE SERVICES	2709 GARY ROAD ROCKY MOUNT, NC 27803

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a treatment plan was updated annually for one of three audited clients (#1). The findings are: Review on 03/22/18 of client #1's record revealed: -admission date: 08/26/10 -diagnoses which included Hypertension and Paranoid Schizophrenia -treatment plan dated 06/07/16 with goals to continue to improve his health, to keep going to Psychosocial Rehabilitation (PSR) and find things to do to keep busy. No revisions or update made to the plan since 2016. During interview on 03/22/18, Chief Financial Officer reported: -treatment plan not updated because client #1 did not attend a PSR During interview on 03/22/18, the company's President reported: -agency did have a Qualified Professional...a year ago, agency decided to have treatment plans completed by the PSR -she was not aware client #1 did not have a current treatment plan	V 112		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL064-075 Y1	A. Building B. Wing Y2	3/23/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BTW HOME CARE SERVICES	2709 GARY ROAD ROCKY MOUNT, NC 27803

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 03/23/2018	ID Prefix V0121 Reg. # 27G .0209 (F) LSC	Correction Completed 03/23/2018	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR India Vaughn-Rhodes	DATE 3.29.18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/27/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: KMQ412