		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
					R	
		MHL064-075	B. WING		04/0	2/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BTW HOM	E CARE SERVICES	2709 GAR				
DIVI IION	E OAKE GEKVIOEG	ROCKY M	OUNT, NC 278	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An Annual and Follow Up Survey was completed 4/2/19. A deficiency was cited.					
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	"A sister facility is identified in this report. The sister facility will be identified as sister facility A. Clients will be identified using the letter of the facility and a numerical identifier."					
	*notation: this is a family owned business and for better understanding of this report, the staff are as follows:					
	Licensee #1 (husband Licensee #2 (wife)	d)				
V 290	27G .5602 Supervise	d Living - Staff	V 290			
	10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.					
	present at all times w premises, except who habilitation plan docu	e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is				
	without supervision. as needed but not les the client continues to	in the home or community The plan shall be reviewed st than annually to ensure be capable of remaining in				
	specified periods of ti (c) Staff shall be pres					

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

(X6) DATE TITLE

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	A. Bollbirto.		R	
		MHL064-075	B. WING			02/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
BTW HOM	IE CARE SERVICES	2709 GAI					
B111111011	IL GARL GLIVIGLG	ROCKY	MOUNT, NC 278	03			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 290	abuse disorders shall of one staff present for clients present. How present during sleeping emergency back-up the governing body; of (2) children or a developmental disabition one staff present for present and two staff more clients present. In the dispresent during specified by the emer determined by the go (d) In facilities which diagnosis is substance (1) at least one duty shall be trained in withdrawal symptoms secondary complicating addiction; and (2) the services abuse counselor shall as-needed basis for each of the services abuse counselor shall as-needed basis for each on observation interview the facility for one staff member was when a client's treatmedient was capable of	ient is present: adolescents with substance be served with a minimum or every five or fewer minor ever, only one staff need be ing hours if specified by the procedures determined by or adolescents with lities shall be served with every one to three clients present for every four or However, only one staff ing sleeping hours if regency back-up procedures everning body. serve clients whose primary the abuse dependency: the staff member who is on in alcohol and other drug to and symptoms of tons to alcohol and other as of a certified substance I be available on an each client. as evidenced by: in, record review and ailed to ensure a minimum of the present at all times except inent plan documented the inemaining in the community or 4 of 5 current clients (#1,	V 290				
	Review on 3/11/19 of	client #3's record revealed:					

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		MHL064-075	B. WING		R 04/02/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	ΓE, ZIP CODE	
DTW HOM	IE CADE SEDVICES	2709 GAF	RY ROAD		
BIW HOW	IE CARE SERVICES	ROCKY N	IOUNT, NC 2780	03	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
V 290	Continued From page		V 290		
	 admitted to the fa 				
		d Intellectual Disability;			
	Schizophrenia & Hea				
	· ·	dated 7/10/18 revealed no			
	documentation of uns				
		dated 9/5/17 - "hearing its have discussed hearing			
	evaluation which he re				
	Cvaldation which he is	epeatry refused			
	Review on 3/15/19 of a North Carolina offender				
	search for client #3 revealed:				
	- convicted 4/16/98	3 for robbery with dangerous			
	weapon				
	 released from pri 	son on 1/7/09			
	Review on 3/12/19 of	an incident report dated			
	1/11/19 (time 5pm) fo				
	- "on Friday 1/11	/19 during and outing to			
	[another county] [clier				
		ad stopped at [restaurant]			
		nd to grab something to eat			
		estaurants. When we met			
		nt #3] was not to be found.			
		nrooms and dining areas of			
		staurants to no availability inty of outing] and has lots			
		here so we knew he was			
	_	surroundings. We also knew			
		f person to talk to or get on			
		ers. [Client #3's guardian]			
	(department of social				
		tep was to contact his family			
	to see if by chance or				
		ched out to known family			
		edia and instructed them to			
		s possiblewe received no			
		.the next morning (1/12/19)			
		nt back to [county of outing]			
		2:30pm [client #3]'s sister ad seen the message on			

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		GOWII ELTED	
					R	
		MHL064-075	B. WING		04/02/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
D.T		2709 GAF	RY ROAD			
BIWHOM	IE CARE SERVICES	ROCKY N	IOUNT, NC 278	803		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULI	D BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	
V 290	Continued From page	e 3	V 290			
	social media. She wo	ould call [client #3's] mom				
	_					
	immediately wanted t	o know why a silver alert				
	was placed for her so	nhe was fine. [Client #3]'s				
	. ,	-				
	_ =	-				
	managed to leave wit	hout being seen. [Client #3]				
	said that when we lef	t [restaurant] he went behind				
	_					
	-					
	nim to his mother's no	ouse.				
	 Review on 3/18/19 of	a notice service report				
		•				
	around 10:00pmthe	couple (Licensee #1 & #2)				
	advised they came to	[another county] with their				
		•				
	T =	-				
	returned to the van. T	ecified time [Licensees']				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:			
			_		_	
					R	
		MHL064-075	B. WING		04/02/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	TO VIDER OIL OUT FEILIN					
BTW HOM	IE CARE SERVICES	2709 GAF				
		ROCKY N	OUNT, NC 278	03		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE	
				DETIGIENCY)		
V 290	Continued From page	<u> </u>	V 290			
	. •					
	resident who was not					
	#3]another resident	advised that [client #3] did				
		an earlier to get food. Others				
	even offered to have	[client #3] walk with them,				
	but he declined and ju	ust asked them to bring him				
	something back to ea	tthey could not provide				
	any further details abo	out where [client #3] went,				
	-	if he was with anyone, or if				
		it is believed that each				
	~	some sort of cognitive				
	impairment and could	_				
		e #1 advised the delay in				
		them searching for [client				
	#3]he is hard of hea	y -				
		was timid and keeps to				
		of troublea media release				
	•	t canceled on 1/12/19"				
	was dollesilver aler	Canceled on 1/12/19				
	Daviou on 2/15/10 of	Ding mana rayaalad:				
	Review on 3/15/19 of					
	•	o the restaurant was 58				
	minutes					
		ant to client #3's mother's				
	home would take 16 r	<u> </u>				
		vehicle would take 3				
	minutes to client #3's	mother's home				
		19 at 11:22am revealed:				
	 the restaurant was 	as located off a busy 6 lane				
	highway					
	 one of the 6 lane 	highway was under				
	construction					
	- the speed limit w	as 45 miles per hour				
	- the restaurant wa	as located near 2 other				
	restaurants					
	During interview on 3	/11/19 client #1, #4 & #5				
	was not able to recall					
	During interview on 3	/11/19 client #2 reported:				
		e of the 1/11/19 incident				

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED
					_D
		MUL 004 075	B. WING		R 04/02/2019
		MHL064-075			04/02/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2709 GAF	Y ROAD		
BTW HON	IE CARE SERVICES	ROCKY N	OUNT, NC 278	03	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)	
V 290	Continued From page	5	V 290		
	. •				
	~ .	and another group home			
	went on an outing				
	 they stopped at a 				
	 he recalled the L 	icensee's went in the			
	restaurant but was no	ot sure whyhe thought to			
	use the bathroom				
	 the clients stayed 	d on the van			
	- client #3 got off t	he van			
	- he was not sure	which way client #3 went			
	- he was not sure the time of the day				
	- he could not reca	all anything else on 1/11/19			
	During interview on 3	/11/19 client #A5 reported:			
		ered food from a restaurant			
	around 5:05pm				
		& the guys from two sister			
	facilities went to pick				
		alked to another restaurant			
		2 went in the restaurant to			
	get food				
	• •	ack to the van, client #3 was			
	gone				
	D	/44/40 -1:			
		/11/19 client #3 reported:			
	- he recalled the 1				
		ome town with the Licensees' as inside the restaurant			
		n and walked to his mother's			
	house	wheely where he was asing			
		ybody where he was going			
	- it was not a long				
		stay out the way of traffic			
	•	ght at his mother's home and			
	had one 40 ounce be	CI			
	During inton/iow on 2	/11/10 client #3's quardian			
	reported:	/11/19 client #3's guardian			
	-	of the 1/11/19 incident			
		he area his mom lived			

he wanted to see his mother

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חוטופועום	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MHL064-075	B. WING		04/02/2019	
NAME OF B	DOVIDED OD OUDDUED	OTDEET A	DDEGG OITY OTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
BTW HOM	IE CARE SERVICES		RY ROAD			
		ROCKY	MOUNT, NC 278	03		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
V 290	Continued From page	. 6	V 290			
. 200	Continued From page	. 0	1200			
	 he saw somebod 	ly he knew at the restaurant				
	and left with them					
	- his mother reside	es 3 minutes from the				
	restaurant					
	 he would have to 	cross the 6 lane highway to				
	get to his mother's ho	0 ,				
	•	ut concerns of crossing the				
		ded "he was able to make it				
	to his mom's house"	ded Tie was able to make it				
		d				
		d manneredhe does not				
	raise his voicehe's r					
		any trouble since his release				
	from prison					
	 client #3 could he 					
		rvision concerns of the				
	facility					
	 she has placed of 	ther clients at their facilities				
	and there was no issu	ues				
	During interview on 3	/11/19 & 3/18/19 Licensee				
	#1 reported:					
	•	ted something to eat at this				
	restaurant	nea comenmig to car at time				
		pathroom in the restaurant				
		athroom approximately 5-10				
	minutes	atiliooni approximately 5-10				
	- all the clients we	ro loft on the yen				
		ed to the van, client #3 was				
	gone					
		not aware of client #3's				
	whereabouts					
	_	nt #3's grandmother's				
		to have signs of dementia"				
	- they went to a co	ousin's home				
	- she reached out	to family on social media				
	and was able to locate	e client #3				
	 later found out he 	e left with a family member				
		ru line at the restaurant				
		er took him to his mother's				

house
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	or rieditir Service Regu				T		
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		1 ' '	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
				R			
		MUI 064 075	B. WING			2040	
		MHL064-075			04/02/	2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		2709 GAF	RY ROAD				
BTW HON	IE CARE SERVICES		NOUNT, NC 278	103			
			100111, 110 270				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETE	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE	
IAO		,	170	DEFICIENCY)			
			_				
V 290	Continued From page	2 7	V 290				
	- if he walked to hi	s mother's home he would					
	have to cross the bus						
		of the speed limit					
		alk across the busy					
	highway						
		its will be supervised at all					
	times						
		/11/19 & 3/18/19 Licensee					
	#2 reported:						
	 he had a taste fo 	r some food at this					
	restaurant						
	- he & Licensee #1	I went into the restaurant to					
	get them a plate						
	- the clients stayed	d on the van					
	-	first of the month, so this was					
	not an outing	·					
	_	t have any money to go to					
	the different restaurar						
	- the clients liked to	o ride out so he took clients					
		ies (approximately 8-10					
	males)	ies (approximately e re					
	·	as busy so they were in the					
	restaurant approxima	-					
		Il given permission to any					
	clients to get off the v						
		ensee #1 returned to the					
	van. client #3 was not						
	_ ,	v minutes to see if client #3					
	_	but he did not return to the					
		but he did not return to the					
	van	three restaurants in the less!					
	1	three restaurants in the local					
	area and he was not t						
		#1 at the restaurant in case					
	client #3 returned to t						
		he block to look for client #3					
	 he was not able t 						
		able to locate client #3					
	through social media						
- client #3 said he walked to a friend's house 2							

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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	
						R
		MHL064-075	B. WING		04	1/02/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
TVAIVIL OF T	NOVIDER OR OUT FEET		RY ROAD	, ZII OOBL		
BTW HON	ME CARE SERVICES		MOUNT, NC 27803			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	COMPLETE DATE
V 290	Continued From page	e 8	V 290			
	blocks away					
	,	im to his mother's home				
	- the highway in fr	ont of the restaurant was				
	dangerous due to tra					
	- he was aware of	client #3's criminal				
	historythere was no facility	problems with him at the				
	- this was the first	time he had eloped				
		ave been reassessed, clients				
	will be supervised by	staff at all times				
	Review on 3/20/19 of a Plan of Protection written					
	by Licensee #2 revealed: "accessements for all					
		evaluated immediately. Until				
		nplete consumers shall not				
		the home or community				
		sion. [Chief Financial Officer]				
	shall ensure that the	above policy is followed"				
		ed to the facility in 2016 with				
	diagnoses of Mild Int	3 ·				
		aring Disability. Based on a				
		nt #3 has repeatly refused a				
	_	ue to "hearing deficit limits." ed to the facility he was				
	incarcerated 11 years	•				
	_	On 1/11/19 Licensee #2 had				
	a taste for some food					
		nutes from the facility.				
		ok clients from 2 different				
		ely 8 - 10 clients) with them				
	1 7 7	restaurant was located on a				
	_	and in the hometown of				
		port revealed the group				
	1	do and allowed the males to				
	1 -	s of their choice. However,				
	the Licensees' report	ed all clients remained on				
	the van, while they (L	icensee #1 & #2) went into				
		them (Licensee #1 & #2)				
	some food and use the	he bathroom. It was not the				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			A. BOILDING			
		MHL064-075	B. WING		R 04/02/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2709 GARY	ROAD			
BTW HOM	IE CARE SERVICES	ROCKY MO	OUNT, NC 278	803		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
	Continued From page first of the month so the money to purchase an just for the ride. Base the 10 clients had unscommunity which did they returned client #3 #3 said he walked to her. He had one 40 or there. Bing maps revet the restaurant to client approximately 16 min reported client #3 had highway to get to his was put in place and enext day (1/12/19). The Type B rule violation whealth, safety or welfaviolation is not correct.	ne clients did not have any my food. The clients went d on the Licensees' only 2 of supervised time in the not include client #3. When 3 was not on the van. Client his mother's home to visit unce beer while he was caled walking distance from at #3's mother's home was utes. The Licensees' I to cross a busy 6 lane mother's home. A silver alert client #3 was located the his deficiency constitutes a which is detrimental to the are of the clients. If the ted within 45 days, an of \$200.00 per day will be the facility is out of		CROSS-REFERENCED TO THE APPROPI		

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