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 _____	02/24/2020

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 2/24/20. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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 _____	02/24/2020

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 118	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to keep MARs current and record immediately after administration for 1 of 3 audited clients (#1). The findings are: Review on 2/18/20 of client #1's record revealed: -Admission date of 08/30/07. -Diagnoses of Schizophrenia, Paranoid, Asperger's Syndrome -Physician's order written 11/24/19 - Atorvastatin Calcium 20mg-take 1 tablet by mouth daily (used to treat cholesterol and fats). -Divalproex sodium ER coated 500mg- take 4 tablets by mouth at bedtime (used to treat various types of seizure disorders/used to treat manic episodes related to bipolar disorder). -Lorazepam 1mg- take 1 tablet by mouth at bedtime (used to treat insomnia due to anxiety). -Mar not signed 2/17/20 for any of the medications listed above. During interview on 2/18/20 the Chief Financial Officer reported: -Staff should check and sign MAR daily. -Confirmed MAR not signed 2/17/20. -Checks MAR weekly -Qualified Professional checks monthly.	V 118		
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	V 736		

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 _____	02/24/2020

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 736	Continued From page 2 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 a safe, clean, attractive and orderly manner. The findings are: Observations on 2/18/20 between 3:05 pm and 3:35 pm revealed the following: -client #3 and #2's bedroom blinds were broken in need of repair. -5 to 10 boxes of protective underwear stored in the bedroom stacked beside client #2's bed. -hallway bathroom 2 out of 4 light bulbs were missing. -client #4 and #1's bedroom: -client #4's dresser had 2 out of 5 drawers missing. -bathroom in the room had no shower curtain. -bathroom missing 2 out of 6 light bulbs. -the entire light fixture rusted. -bathtub covered with brown dirt/mildew spots throughout. Interview on 2/18/20 between 3:05pm and 3:35pm Chief Financial Officer reported: -the blinds break when clients peek out, they had just been replaced. -the pharmacy continues to mail several boxes of the protective underwear a month, they have more than enough. -clients complain about the bathroom being to bright. -will need to replace the dresser.	V 736		

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 _____	02/24/2020

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 736	Continued From page 3 -doesn't know what happened to the shower curtain but will get one to put in there. -confirmed light fixture was rusted. - clients clean the bathroom and their bedrooms weekly.	V 736		