Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL032371	B. WING		R 09/28/2021
		<u> </u>			00/20/2021
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY,	STATE, ZIP CODE	
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	OOK ROAD AM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 000	INITIAL COMMENT	rs	V 000		
	on September 28, 2 This facility is licens	w-up survey was completed 2021. Deficiencies were cite sed for the following service C 27G .5600A Supervised h Mental Illness.	d.		
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112		
	PLAN (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall i (1) client outcome(achieved by provisi projected date of ac (2) strategies; (3) staff responsible (4) a schedule for annually in consultaresponsible person (5) basis for evalua outcome achievement (6) written consent responsible party, consultaresponsible party, consu	De developed based on the partnership with the client of person or both, within 30 datents who are expected to yond 30 days. Include: (a) that are anticipated to be con of the service and a chievement; (b) the plan at least attion with the client or legally or both; attion or assessment of	or nys		

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:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL032371	B. WING			₹ 2 8/2021
	PROVIDER OR SUPPLIER CASTLE RESIDENTIA	AL SERVICES INC 505 COO		TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 1	V 112			
	facility failed to have Plan with written coclient's responsible by the provider stat not be obtained affer reviewed (#1, #2 are Review on 9/28/21 the following: -Admission date of -Diagnoses of Bord Severe Acne; Pervarent Enuresis Intermittent Explosi -Client #1 had a leg -Client #1's Person consent or agreement	views and interview, the e an updated Person Centered pasent or agreement by the party, or a written statement ing why such consent could ecting three of three clients and #3). The findings are: of Client #1's record revealed 7/16/13. Iterline Intellectual Functioning; asive Developmental Disorder; by Chizoaffective Disorder: by Disorder Plan had no written ent by the responsible party or by the provider stating why				
	the following: -Admission date of -Diagnoses of Hype Type II; Schizoaffed Gastroesophageal Hip Osteoarthritis; I -Client #2 had a leg -Client #2's Person consent or agreeme	ertension; Diabetes Mellitus ctive Disorder; Reflux; Hyperlipidemia; Right Dyslipidemia; Renal Mass. gal guardian assigned to him. Centered Plan had no written ent by the responsible party or by the provider stating why				
	Review on 9/28/21 the following:	of Client #3's record revealed				

6899

Division of Health Service Regulation STATE FORM

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		
		MHL032371	B. WING		09/2	R 18/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	1 00	
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COO	K ROAD I, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 2	V 112			
	Hypertension; Histor-Client #3 had a leg-Client #3's Person consent or agreemed a written statement such consent could	noid Schizophrenia; ory of Alcohol Abuse. gal guardian assigned to him. Centered Plan had no written ent by the responsible party or by the provider stating why I not be obtained.				
	Interview on 9/28/21 with the Program Manager revealed: -The Qualified Professional was responsible for completing the Person Centered PlansBecause of COVID situation, they had some trouble getting the client's guardian's signatures on their Person Centered PlansShe confirmed that the Person Centered Plans for clients #1, #2 and #3 had no written consent or agreement by their responsible party or a written statement by the provider stating why such consent could not be obtained.					
	This deficiency con and must be correct	stitutes a re-cited deficiency sted within 30 days.				
V 113	(a) A client record s individual admitted contain, but need n (1) an identification	206 CLIENT RECORDS shall be maintained for each to the facility, which shall ot be limited to: face sheet which includes:	V 113			
	(A) name (last, first (B) client record nu (C) date of birth; (D) race, gender an (E) admission date; (F) discharge date; (2) documentation (C)	mber; nd marital status;				

Division of Health Service Regulation

STATE FORM 6899 D4XD11 If continuation sheet 3 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLICATION OF COMPLETED	
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	∃D
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MHL032371 B. WING 09/28/202	024
MITILU32371 - U3/20/202	JZ I
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
505 COOK ROAD	
ROSE'S CASTLE RESIDENTIAL SERVICES INC DURHAM, NC 27713	
	(VE)
	(X5) OMPLETE
IAG STORE THE THE STATE OF THE	DATE
DEFICIENCY)	
V 113 Continued From page 3 V 113	
developmental disabilities or substance abuse	
diagnosis coded according to DSM IV;	
(3) documentation of the screening and	
assessment; (4) treatment/habilitation or service plan;	
(5) emergency information for each client which	
shall include the name, address and telephone	
number of the person to be contacted in case of	
sudden illness or accident and the name, address	
and telephone number of the client's preferred	
physician;	
(6) a signed statement from the client or legally	
responsible person granting permission to seek	
emergency care from a hospital or physician;	
(7) documentation of services provided;	
(8) documentation of progress toward outcomes;	
(9) if applicable:	
(A) documentation of physical disorders	
diagnosis according to International Classification of Diseases (ICD-9-CM);	
(B) medication orders;	
(C) orders and copies of lab tests; and	
(D) documentation of medication and	
administration errors and adverse drug reactions.	
(b) Each facility shall ensure that information	
relative to AIDS or related conditions is disclosed	
only in accordance with the communicable	
disease laws as specified in G.S. 130A-143.	
This Dule is not not as suideneed by	
This Rule is not met as evidenced by:	
Based on records reviews and interview, the	
facility failed to assure a complete record was maintained for each client which included	
medication prescriptions affecting 2 of 3 audited	

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 4 of 21 D4XD11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						ı	₹
		MHL032371		B. WING		09/2	28/2021
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	505 COOL	ROAD , NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 113	clients (#2 and #3). 1. Review on 9/28// revealed the follow -Admission date of -Diagnoses of Hype Type II; Schizoaffed Gastroesophageal Hip Osteoarthritis; Review on 9/28/21 Administration Rec through September -Cetirizine 10 mg-6 -Finasteride 5 mgFluticasone 50 mc nostril dailyDiclofenac Sodium area Four times as -Hydroxyzine 50 mg -All medications we Observation on 9/2 medications reveal -Cetirizine 10 mg-1 -Finasteride 5 mg -Fluticasone 50 mg -Fluticasone 50 mg -Diclofenac Sodium availableHydroxyzine 50 mg Review on 9/28/21 no copies of prescrimedications. 2. Review on 9/28/21 revealed the follow -Admission date of	The findings are: 21 of Client #2's recoing: 12/31/06. ertension; Diabetes Motive Disorder; Reflux; Hyperlipidem Dyslipidemia; Renal Motive In 19 (MAR) from July 19	Mellitus iia; Right Mass. ation 2021 each fected time. Client #2's able. available. vailable. vailable. revealed above	V 113	DEFICIENC		
		anoid Schizophrenia; ory of Alcohol Abuse.					

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o. '	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				A. BUILDING:			R	
		MHL032371	E	B. WING			8/2021	
NAME OF F	PROVIDER OR SUPPLIER	STR	REET ADDR	RESS, CITY, S	TATE, ZIP CODE			
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	COOK I	ROAD NC 27713				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 113	Continued From pa	age 5		V 113				
	2021 through Septer-Clozapine 50 mg-Melatonin 5 mg- Co-Medications were Observation on 9/2 medications reveal-Clozapine 50 mg-Melatonin 5 mg- Molatonin 5 mg-	28/21 at 11:10 am of Clientled: Medication was available Medication was available. of Client #3's record reversitions for any of the about 1 with the Program Manale that some of the client's	at #2's e. ealed ve					
	medication orders were not on fileClient #3 was scheduled to see his Doctor for 10/7/21 to renew his medication ordersShe confirmed that Client #2 and #3's records were missing copies of prescriptions for some of the medications they received.							
V 114	27G .0207 Emerge	ency Plans and Supplies		V 114				
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved I authority. (b) The plan shall b and evacuation pro posted in the facilit (c) Fire and disaster	an for each facility and plan shall be developed a by the appropriate local one made available to all stocedures and routes shall y. er drills in a 24-hour facilit st quarterly and shall be	and taff be					

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STATE FORM D4XD11 If continuation sheet 6 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL032371		B. WING			R 28/2021
	PROVIDER OR SUPPLIER	AL SERVICES INC	505 COO		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 114	repeated for each s under conditions th	ge 6 shift. Drills shall be c at simulate fire eme all have basic first aid	rgencies.	V 114			
	facility failed to contain that simulate emerg	et as evidenced by: views and interviews duct fire drills under gencies at least qual shift. The findings a	conditions rterly and				
	log revealed: -2/11/21- 1st shift5/12/21- 1st shift8/8/21- 1st shiftThere were no fire 2nd shift for the fou	drills conducted for drills conducted for drills conducted for drills conducted for conducted for cond quarter of 2021	1st and 2nd shift				
	drill log revealed: -1/8/21- 1st shiftThere were no disa and 2nd shift for the -There were no disa 2nd shift for the firs -There were no disa	aster drills conducte e fourth quarter of 20 aster drills conducte t quarter of 2021. aster drill conducted e second and third q	d for 1st 020. d for the for 1st				
	revealed: -Facility operated u	n 7:00 AM to 7:00 PM	-				

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STATE FORM 6899 D4XD11 If continuation sheet 7 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		MHL032371		B. WING	B. WING		R 09/28/2021	
	PROVIDER OR SUPPLIER CASTLE RESIDENTIA	AL SERVICES INC	505 COOI		STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES / FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 114	-Staff were confuse disaster drills had to -She confirmed sta conditions that simile each shift on each	ed on how often the for be conducted. If failed to conduct dulate fire emergencing quarter. Stitutes a re-cited de	Irills under es under	V 114				
V 118	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, incadministered only bunicensed persons pharmacist or other privileged to prepare (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests	inistration: non-prescription druged to a client on the vertical by law to puthorized by law to puthorized in writing believed in writing by licensed persons, a trained by a register legally qualified per legand administer meliministration Record red to each client must administered shallely after administration.	gs shall written brescribe red by by the hall be or by red nurse, rson and edications. (MAR) of ust be kept be on. The drug; ug; red; and ering the	V 118				

Division of Health Service Regulation

STATE FORM 6899 D4XD11 If continuation sheet 8 of 21

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 BOILBII10.		F	۲
		MHL032371	B. WING			8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOI	K ROAD , NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 118	'	ge 8 appointment or consultation	V 118			
	interviews, the facil medications were a affecting three of th and 2. Failed to kee Administration Rec	ion, record reviews and ity failed to 1. Ensure available for administration aree clients (#1, #2 and #3)				
	1.The following is e ensure medications administration.	vidence the facility failed to swere available for				
	the following: -Admission date of -Diagnoses of Bord Severe Acne; Perva	lerline Intellectual Functioning; asive Developmental Disorder; chizoaffective Disorder:				
	orders revealed: -Orders dated 2/16, -Cetirizine 10 n dayMulti-VitaminSenna 8.6 mg	of Client #1's physicians /21: nilligrams (mg)- One tablet a One tablet a day One tablet a day. ale two puffs every 4 hours as				

	UT OF DEFICIENCIES		(MO) MILII TIDI	F CONCEDUCTION	(VO) DATE	OLIDVEN.
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMPI	
		.s.c	A. BUILDING:	·		·
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		MHL032371	B. WING		09/2	8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE ZIP CODE		
TO WILL OF T	NOVIDER OR GOLT EIER		OOK ROAD	57/11 C, Zii GGBE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC				
			IAM, NC 27713			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 118	Continued From pa		V 118			
V 110	Continued i form pa	ge 9	V 110			
		8/21 at 11:00 am of Client #	[£] 1's			
	medications revealed					
		rams mg- There was none				
	available at the hon					
	home.	re was none available at the	9			
		ere was none available at tl	20			
	home.	ere was none available at ti				
		ion on site had expired on				
		not a new one available at t	he			
	home.					
	Review on 9/28/21	of Client #1's MARs for July	/			
		ember 2021 revealed:				
		rams (mg)- Blanks from 9/2	25-			
	9/28.					
		nks from 9/25- 9/28.				
	-Senna 8.6 mg- Bla	inks from 9/25- 9/28.				
	Daview en 0/00/04	of Client #2's record reveal	- d			
	the following:	of Client #2's record reveal	eu			
	-Admission date of	12/31/06				
		ertension; Diabetes Mellitus				
	Type II; Schizoaffed					
	7 1	Reflux; Hyperlipidemia; Rig	ht			
		Dyslipidemia; Renal Mass.				
	•					
		of Client #2's physician's				
	orders revealed:					
	-Orders dated 2/16/					
		sylate 10 mg- One tablet d				
		osage 81 mg- One tablet da	ally.			
		mg- One tablet daily.				
	-Multivitamin- C -Order dated 9/23/2	-				
		ng- One tablet daily.				
		ication was missing orders:				
		ng- One tablet daily.				
		2				

Division of Health Service Regulation

	of Fleatiff Service IN				T	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AIND ELAIN	OI CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COIVIP	LLILD
					F	₹
		MHL032371	B. WING			8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DECC CITY O	STATE, ZIP CODE		
NAIVIL OF I	-NOVIDEN ON SUFFEIEN	505 COOK		STATE, ZIF GODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	NC 27713			
		<u> </u>	NC 21113			
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 118	Continued From pa	ge 10	V 118			
V 110	·		V 110			
		8/21 at 11:10 am of Client #2's				
	medications revealed					
		te 10 mg- There was none				
	available at the hon					
		e 81 mg- There was none				
	available at the hon					
	the home.	There was none available at				
		was none available at the				
	-Multivitamin- There was none available at the home.					
	-Jardiance 10 mg- There was none available at					
	the home.	There was hone available at				
		There was none available at				
	the home.	There was hells available at				
	Review on 9/28/21	of Client #2's MARs for July				
	2021 through Septe	ember 2021 revealed:				
		te 10 mg- Blanks from 9/25-				
	9/28.					
		e 81 mg- Blanks from 9/25-				
	9/28.	DI I (0/05 0/00				
		Blanks from 9/25- 9/28.				
	-Multivitamin- Blank					
		Blanks from 9/25- 9/28. Blanks from 9/25- 9/28.				
	-Finastenue 5 mg-	Bianks 110111 9/20- 9/20.				
	Review on 9/28/21	of Client #3's record revealed				
	the following:	or Olient #03 record revealed				
	-Admission date of	2/23/12.				
		noid Schizophrenia;				
		ory of Alcohol Abuse.				
	,					
	Review on 9/28/21	of Client #3's physician's				
	orders revealed:					
	-Physician's orders					
	-Multivitamin- C					
		5 mg- One tablet twice daily.				
	-Senna 8.6 mg-	two tablets twice daily.				
	0 1	0/04 / 44 40				
	Observation on 9/2	8/21 at 11:10 am of Client #3's				

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		R	
		MHL032371	B. WING			8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOI	K ROAD , NC 27713			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 11	V 118			
	homeBenztropine 0.5 m at the home.	ed: e was none available at the g- There was none available ere was none available at the				
	Review on 9/28/21 of Client #3's MARs for July 2021 through September 2021 revealed: -Multivitamin- Blanks from 9/25- 9/28Benztropine 0.5 mg- Blanks from 9/25- 9/28Senna 8.6 mg- Blanks from 9/25- 9/28.					
	2. The following is keep the MAR curr	evidence the facility failed to ent.				
	Review on 9/28/21 of Client #1's record revealed the following: -Admission date of 7/16/13Diagnoses of Borderline Intellectual Functioning; Severe Acne; Pervasive Developmental Disorder; Recurrent Enuresis; Schizoaffective Disorder: Intermittent Explosive Disorder.					
	orders revealed:	of Client #1's physicians nilligrams (mg)- One tablet a				
	-Multi-Vitamin- -Senna 8.6 mg -Amantadine 1 morning; One caps night.	One tablet a day One tablet a day. 00 mg- One capsule in the cule at noon; One capsule at 5 mg- One tablet in the				
	morning; Two table pm; One tablet at b -Oxybutynin 5 i day.	ets at noon; Two tablets at 4:00				

Division of Health Service Regulation

MHL032371 NAME OF PROVIDER OR SUPPLIER R B. WING		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL032371 B. WING 09/28/202				A. BUILDING.		D	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			MHL032371	B. WING			
	NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S CASTLE RESIDENTIAL SERVICES INC 505 COOK ROAD DURHAM, NC 27713	ROSE'S C	CASTLE RESIDENTI	AL SERVICES INC				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
V 118 Continued From page 12 the moming; Two capsules at night. -Clozapine 100 mg- Three tablets in the evening with meals; Four tablets at bedtime. -Divalproex Sodium 250 mg- Three tablets at night. Observation on 9/28/21 at 11:00 am of Client #1's medications revealed: -Cettrizine 10 milligrams (mg)- Medication was not available. -Multi-Vitamin- Medication was not available. -Amantadine 100 mg- Medication was available. -Lorazepam 0.5 mg- Medication was available. -Lorazepam 0.5 mg- Medication was available. -Lithium Carbonate 300 mg- Medication was available. -Divalproex Sodium 250 mg- 9/25-9/28. -Amantadine 100 mg- 9/25-9/28. -Lorazepam 0.5 mg- 9/25-9/28. -Divalproex Sodium 250 mg- 9/25-9/28.		the morning; Two conclosure 100 evening with meals -Divalproex Sonight. Observation on 9/2 medications reveal -Cetirizine 10 million not available. -Multi-Vitamin- Mecona -Senna 8.6 mg- Mecona 8.6 mg- Mecona -Corazepam 0.5 mg- Corazepam 0.5 mg- Corazepam 100 mg- Corazepam 100 mg- Civalproex Sodium available. Review on 9/28/21 September 2021 Molanks on the followord -Cetirizine 10 milliog -Multi-Vitamin- 9/28 -Senna 8.6 mg- 9/20 -Amantadine 100 mg- Corazepam 0.5 mg- Corazepam 0.5 mg- Corazepam 0.5 mg- Civalproex Sodium Review on 9/28/21 the following: -Admission date of -Diagnoses of Hypersecond -Clozapine 100 mg- Corazepam 0.5 mg- Clozapine 100 mg-	apsules at night. Img- Three tablets in the Img- Three tablets at bedtime. dium 250 mg- Three tablets at 8/21 at 11:00 am of Client #1's ed: Imams (mg)- Medication was dication was not available. Ing- Medication was available. Ing- Medication was available. Ing- Medication was available. Img- Medication was available. Img- Medication was available. Img- Medication was available. Img- Medication was	V 118			

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Division of Health Service Regulation

ווטופועום	of Health Service Re	eguiation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUME	BEK:	A. BUILDING:		COMPLETED	
						_	,
		MHL032371		B. WING		R 09/28/2021	
		WITILU3237 I				03/2	.0/ZUZ I
NAME OF I	PROVIDER OR SUPPLIER	S	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
			05 COOK	ROAD			
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	OURHAM.	NC 27713			
0/4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	,		DDOVIDEDIS DI ANI OF CORDECTIO	ON.	()(5)
(X4) ID PREFIX	-	/ MUST BE PRECEDED BY FU	JLL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATI		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
\/ 118	Continued From pa	ige 13		V 118			
V 110	Continued i Tom pa	ige 10		V 110			
	Hip Osteoarthritis; I	Dyslipidemia; Renal Ma	ass.				
		of Client #2's physiciar	า'ร				
	orders revealed:						
	-Orders dated 2/16						
		sylate 10 mg- One tab					
		osage 81 mg- One tabl	et daily.				
		g- One tablet daily.					
		mg- One tablet daily.					
		mg- One tablet daily.					
	-Multivitamin- C						
		4 mg- One capsule dai					
		ium 100 mg- One caps	sule				
	twice a day.						
		g- One tablet twice a d					
		0 mg- One tablet twice					
		mg- One tablet at nig					
	•	dium 250 mg- Three ta	blets at				
	bedtime.	.,					
	-Order dated 9/23/2						
		ng- One tablet daily.					
	•	ications were missing t	heir				
	orders:	0 (11 (11					
		ng- One tablet daily.					
		ng- One tablet daily.					
) mcg- Instill 2 sprays in	n eacn				
	nostril daily.	P 4 0/ I A I . 4					
		dium 1 % gel- Apply to					
	affected area Four		IA!				
	-myaroxyzine 5	0 mg- Two tablets at be	eaume.				
	Observation on 0/2	8/21 at 11:10 am of Cli	ont #2'o				
	medications reveale		C111 #∠ S				
			vac not				
	available.	te 10 mg- Medication v	vas 110t				
		ao 91 mai Madiaation :	vac not				
		ge 81 mg- Medication w	vas 110t				
	available.	adjection was available	_				
		edication was available					
		Medication was availa					
	-bupropion 40 mg-	Medication was not av	aliable.				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPLETED	
					R	
		MUI 022274	B. WING		09/28/2021	
		MHL032371			09/2	8/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
		505 CO	OK ROAD			
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	M, NC 27713			
	OLIMANA DV. OTA			DDOL/IDEDIO DI ANI OF CODDECTI	DNI .	0.45
(X4) ID PREFIX	-	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
\/ 110	Continued From no	ngo 14	V 118			
V 110	Continued From pa	ige 14	V 110			
	-Multivitamin- Medi	cation was not available.				
	-Tamsulosin 0.4 mg	g- Medication was available.				
		100 mg- Medication was				
	available.	S				
	-Glipizide 10 mg- M	ledication was available.				
		g- Medication was available.				
		g- Medication was available.				
		n 250 mg- Medication was				
	available.	3				
	-Jardiance 10 mg-	Medication was not available.				
		Medication was available.				
		Medication was not available.				
		g- Medication was available.				
		າ 1 % gel- Medication was				
	available.	9				
	-Hydroxyzine 50 mg	g- Medication was available.				
	Paviou on 0/20/21	of Client #2's MAPs for July				
		of Client #2's MARs for July				
		ember 2021 revealed blanks				
	on the following dat					
		ite 10 mg- 9/25-9/28. ge 81 mg- 9/25-9/28.				
	-Atenolol 50 mg- 9/					
	-Benazepril 40 mg-					
	-Bupropion 40 mg-					
	-Multivitamin- 9/25-					
	-Tamsulosin 0.4 mg					
	-Docusate Sodium					
	-Glipizide 10 mg- 9/					
	-Metformin 1000 m					
	-Atorvastatin 40 mg					
		n 250 mg- 9/25-9/28.				
	-Jardiance 10 mg-					
	-Cetirizine 10 mg- 9					
	-Finasteride 5 mg-					
	-Fluticasone 50 mc					
		n 1 % gel- 9/25-9/28.				
	-Hydroxyzine 50 mg					
	1 TydroxyZino oo mg	g 5,20 5,20.				
	Review on 9/28/21	of Client #3's record revealed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL032371	B. WING			⋜ 28/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOL				
			, NC 27713			
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 15	V 118			
	the following: -Admission date of -Diagnoses of Para					
	orders revealed: -Orders dated 8/26 -Amlodipine Be -Aspirin Low D -Atorvastatin 4 -Citalopram 20 morningFish oil 1000 r -Fluticasone 50 nostril dailyLisinopril 5 mg -Multi-VitaminGabapentin 30 times a day.	esylate 5 mg- One tablet daily. ose 81 mg- One tablet daily. 0 mg- One tablet daily. o mg- One tablet in the mg- Two capsules daily. 0 mcg- Two sprays in each g- One tablet daily. One tablet daily. One tablet daily. 00 mg- One capsule three				
	-Benztropine 0.5 mg- One tablet twice a dayMetformin 500 mg- One tablet twice a daySenna 8.6 mg- Two tablets twice a dayThe following medications were missing their orders: -Clozapine 50 mg- Three tablets at bedtimeMelatonin 5 mg- One tablet at bedtime.					
	medications reveal -Amlodipine Besyla availableAspirin Low Dose availableAtorvastatin 40 mg -Citalopram 20 mg -Fish oil 1000 mg -Fluticasone 50 mg -Lisinopril 5 mg- Mg	28/21 at 11:20 am of Client #3's ed: ate 5 mg- Medication was 81 mg- Medication was g- Medication was available Medication was available. Medication was available. ag- Medication was available. edication was available. dication was not available.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	<u> </u>		
		MHL032371	B. WING		09/2	₹ 8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COO	K ROAD , NC 27713			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 118	Continued From pa	age 16	V 118			
V 118	-Gabapentin 300 m -Benztropine 0.5 m availableMetformin 500 mg -Senna 8.6 mg- Me -Clozapine 50 mg -Melatonin 5 mg- M Review on 9/28/21 2021 through Septe on the following da -Amlodipine Besyla -Aspirin Low Dose -Atorvastatin 40 mg -Citalopram 20 mg -Fish oil 1000 mg -Fluticasone 50 mg -Fluticasone 50 mg -Multi-Vitamin- 9/25 -Gabapentin 300 m -Benztropine 0.5 m -Metformin 500 mg -Senna 8.6 mg- 9/2 -Clozapine 50 mg -Melatonin 5 mg- 8 Interviews on 9/28/revealed: -They liked the hou-Staff always gave	ng- Medication was available. ng- Medication was not l- Medication was not available. dedication was not available. Medication was available. Medication was available. Medication was available. of Client #3's MARs for July ember 2021 revealed blanks tes: nte 5 mg- 9/25-9/28. 81 mg- 9/25-9/28. 9/25-9/28. 9/25-9/28. 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 9/25-9/28. 19- 10- 10- 10- 10- 10- 10- 10- 10- 10- 10	V 118			
	revealed: -Staff at the home sure they complete	1 with the Program Manager were responsible for making of the MAR accordingly. at there were blanks on the				
	-She was aware the medications had ra	at some of the client's in out a few days ago. ming the client's doctors about				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
	MHL032371		B. WING	<u></u>		8/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOP DURHAM.	ROAD NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	Continued From particular having the medicine	es refilled.	V 118			
	-Pharmacist had not brought in the new medicationsShe was expecting the client's new medications to arrive at the house by 3:00 pm todayShe did not know why there were also blank dates in August for Client #3She acknowledged that the MAR was not being completed at the moment when the client's medications had been administeredShe confirmed the facility failed to ensure medications were available for administrationShe confirmed the facility failed to keep the MAR current.					
V 121	121 27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.		V 121			
		et as evidenced by: views and interview the facility g reviews every six months for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			n	
		MHL032371		B. WING			R 28/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	505 COOI DURHAM	K ROAD , NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 121	Continued From pa	age 18		V 121			
		ts (#1, #2 and #3) wl pic drugs. The findi					
	Review on 9/28/21 the following:	of Client #1's record	l revealed				
	-Admission date of		4: !				
		derline Intellectual Fu asive Developmenta					
	Recurrent Enuresis	s; Schizoaffective Dis					
	Intermittent Explos -Physician's order						
	-Lorazepam 0.	5 milligrams (mg,) O					
	in the morning, Two at 4:00 pm; 1 Table	o tablets at noon; Tw et at bedtime	o tablets				
		nate 300 mg, One c	apsule in				
	the morning, Two o		a tha				
) mg, Three tablets in s, Four tablets at bed					
	Divalproex Soc night.	dium 250 mg, Three	tablets at				
		and September 2021 stration Record (MAI					
		was administered th					
	-There was no evid	lence of a psychotro					
	review for Client #1 months.	I's medications in the	e last six				
	Review on 9/28/21 the following:	of Client #2's record	l revealed				
	-Admission date of						
	-Diagnoses of Hype Type II; Schizoaffee	ertension; Diabetes l ctive Disorder:	Mellitus				
	Gastroesophageal	Reflux; Hyperlipiden	, ,				
	Hip Osteoarthritis; -Physician's order	Dyslipidemia; Renal	Mass.				
	-Invega Suster	nna, Inject intramusc	ular every				
	four weeks.	ma One tablet daily					
		mg, One tablet daily dium 250 mg, Three					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
			7.1. 50.25.1.10.			₹
		MHL032371	B. WING			28/2021
NAME OF PROVIDER	OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROSE'S CASTLE	RESIDENTIA	AL SERVICES INC	OK ROAD M, NC 27713			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
bedtime -Lo needed -The Ju Medica reveale medicaThere review months Review the follo -Admis -Diagno Hyperte -Physio -Cir morning -Ga times a -Be -Cle -The Ju Medica reveale medica -There review months Intervie reveale -She w for psyc comple -She w psycho -She co	prazepam 1 in a for agitation agitation agitation agitation agity, August agitions daily. It was no evidence of a for Client #2 in a for Client #2 in a for Client #2 in a for Client #3	mg, One tablet twice a day as n. and September 2021 stration Record (MAR) was administered the above dence of a psychotropic drug l's medications in the last six of Client #3's record revealed 2/23/12. In a consideration of Alcohol Abuse. Dated 8/20/20: mg, One tablet in the company of Alcohol Abuse. Do mg, One capsule three company of Alcohol Abuse and September 2021 stration Record (MAR) was administered the above dence of a psychotropic drug considerations in the last six of the medication reviews edications had to be marmacist review the client's	V 121			

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PRINTED: 10/05/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ R B. WING _ MHL032371 09/28/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 COOK ROAD ROSE'S CASTLE RESIDENTIAL SERVICES INC** DURHAM, NC 27713 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 121 Continued From page 20 V 121 completed.