Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 09/28/2021 MHL032371 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **505 COOK ROAD** ROSE'S CASTLE RESIDENTIAL SERVICES INC DURHAM, NC 27713 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 000 V 000 INITIAL COMMENTS An annual and follow-up survey was completed on September 28, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. V 112 - The Qualified Professional for V 112 V 112 27G .0205 (C-D) Rose's Castle has obtained legal guardian Assessment/Treatment/Habilitation Plan and responsible entity signatures for our ASSESSMENT AND Person-Centered Treatment Profiles. For 10A NCAC 27G .0205 clients whose legal guardian could not sign TREATMENT/HABILITATION OR SERVICE PLAN we have a written consent form giving (c) The plan shall be developed based on the Rose's Castle and other responsible assessment, and in partnership with the client or entities permission to sign Personlegally responsible person or both, within 30 days Centered Treatment Profiles on the legal of admission for clients who are expected to quardian's behalf. 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.

Division of Health Service Regulation

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

TITLE

Oualified Professional

(X6) DATE

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If continuation sheet

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		MHL032371	B. WING		09/28/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOP DURHAM,	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
V 112	-Admission date of -Diagnoses of Para Hypertension; Histo -Client #3 had a leg -Client #3's Person consent or agreem a written statement such consent could Interview on 9/28/2 revealed: -The Qualified Prof completing the Person Celescause of COVID trouble getting the contheir Person Celesche confirmed that for clients #1, #2 ar or agreement by the written statement be such consent could	2/23/12. Inoid Schizophrenia; Ory of Alcohol Abuse. Igal guardian assigned to him. Centered Plan had no written ent by the responsible party or by the provider stating why I not be obtained. 1 with the Program Manager essional was responsible for son Centered Plans. D situation, they had some client's guardian's signatures intered Plans. It the Person Centered Plans ind #3 had no written consent eir responsible party or a y the provider stating why I not be obtained. stitutes a re-cited deficiency	V 112		
V 113	(a) A client record s individual admitted contain, but need n	206 CLIENT RECORDS shall be maintained for each to the facility, which shall ot be limited to: face sheet which includes: middle, maiden); mber; and marital status;	V 113	V 113 - The MedTechs for Rose's (the Program Manager and Owner working with the pharmacist, presphysicians, and prescribing entities assure all medicines prescribed are available for each client. They are working with them to obtain copie prescriptions for all prescribed med The MedTechs are reviewing the N Sheets to ensure they have been completed correctly. All above item be completed by the Nov. 27, 202 deadline.	are cribing s to e e e e also s of dicines. Medicine e e s will

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
						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/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
					R	t
		MHL032371	B. WING		09/2	8/2021
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOP	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 113	Continued From pa	ige 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- Melatonin 6 mg- Melatonin 6 mg- Melatonin 7 mg	8/21 at 11:10 am of Client #2's ed: Medication was available. Medication was available. of Client #3's record revealed riptions for any of the above 1 with the Program Manager e that some of the client's were not on file. Medication orders. It Client #2 and #3's records as of prescriptions for some of				
V 114	10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro-	ency Plans and Supplies 207 EMERGENCY PLANS an for each facility and plan shall be developed and by the appropriate local be made available to all staff ocedures and routes shall be	V 114	V 114 - The Staff for 1st and 2nd sl Rose's Castle have updated the Fi Disaster Drill Manuals to include the missing drills forms that were not placed in the manuals. The Fire a Disaster Drill Manual is up to date	re and he properly and	
		y. er drills in a 24-hour facility st quarterly and shall be				

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		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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Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		MHL032371	B. WING		09/28/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOP				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	NC 27713	PROVIDER'S PLAN OF CORRECTION	ON (X5))
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	ÉTE
V 114	Continued From pa	ige 7	V 114			
	disaster drills had to -She confirmed sta conditions that simile each shift on each	ff failed to conduct drills under ulate fire emergencies under quarter. stitutes a re-cited deficiency				
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or ronly be administered order of a person adrugs. (2) Medications shadlients only when a client's physician. (3) Medications, inclients only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall 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 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, or legally qualified person and re and administer medications. Iministration Record (MAR) of ored to each client must be kept a sadministered shall be ely after administration. The	V 118	V 118 - The MedTechs for Rose's (the Program Manager and Owner working with the pharmacist, presphysicians, and prescribing entitie assure all medicines prescribed an available for each client. They are working with them to obtain copie prescriptions for all prescribed med The MedTechs are reviewing the NSheets to ensure they have been completed correctly. All above iter be completed by the Nov. 27, 202 deadline.	cribing s to e e also s of dicines. Medicine ms will	

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			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; cschizoaffective 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		(VO) MILITIDI	F CONCEDUCTION	(VO) DATE	OLIDVEN.
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		.s.c	A. BUILDING:	·		
					R	₹
		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 COMPLETED	
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				
		e was none available at the				
	home.	e was none available at the				
		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.		F	5
		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				
	2021 through Septe -Multivitamin- Blanl -Benztropine 0.5 m	of Client #3's MARs for July ember 2021 revealed: ks from 9/25- 9/28. g- Blanks from 9/25- 9/28. anks from 9/25- 9/28.				
	2. The following is keep the MAR curr	evidence the facility failed to ent.				
	the following: -Admission date of -Diagnoses of Bord Severe Acne; Perva	derline Intellectual Functioning; asive Developmental Disorder; s; Schizoaffective 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

A. BUILDING: R MHL032371 NAME OF PROVIDER OR SUPPLIER RABURDING: B. WING O9/28/202	
MHL032371 B. WING 09/28/202	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
	NAME OF PROVIDER
ROSE'S CASTLE RESIDENTIAL SERVICES INC 505 COOK ROAD DURHAM, NC 27713	ROSE'S CASTLE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CACH DEFICIENCY PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY) CACH DEFICIENCY CACH DEFICIENCY DEFICIENCY	PRÉFIX (EA
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 mon-clievening -Dirinight. Observe medical -Cetirizen not available -Coxybue -Lithium available -Clozape -Divalpe available -Cetirizen -Amante -Lorazeen -Cetirizen -Amante -Lorazeen -Cetirizen -Amante -Lorazeen -Cetirizen -Amante -Lorazeen -Coxybuen -Lithium -Clozape -Divalpe -Clozape -Divalpe -Clozape -Divalpe -Cetirizen -Clozape -Divalpe -Cetirizen -Clozape -Divalpe -Clozape -Divalpe -Clozape -Divalpe -Clozape -Divalpe -Clozape -Divalpe -Clozape -Cloz

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMB	ER:	A. BUILDING:		COMPLETED	
						_	,
MHL032371			B. WING		R 09/28/2021		
		WITHLU32371				09/2	8/2021
NAME OF I	PROVIDER OR SUPPLIER	S	TREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
			05 COOK	ROAD			
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC		NC 27713			
	OLIMAN DV OTA		7 T tt 11 tt 111,		DDOVIDEDIO DI ANI OE CODDECTIO		41.5
(X4) ID PREFIX	-	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU	11	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)		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0 " 15	40		1/ 440			
V 118	Continued From pa	ige 13		V 118			
	Hip Osteoarthritis; I	Dyslipidemia; Renal Ma	iss.				
	,	, ,					
	Review on 9/28/21	of Client #2's physician	's				
	orders revealed:	. ,					
	-Orders dated 2/16	/21:					
	-Amlodipine Be	sylate 10 mg- One tabl	et dailv.				
		osage 81 mg- One tabl					
		g- One tablet daily.	,				
		mg- One tablet daily.					
		mg- One tablet daily.					
	-Multivitamin- C						
		4 mg- One capsule dail	v				
		ium 100 mg- One caps					
	twice a day.	idili 100 ilig Olio odpo	uic				
		g- One tablet twice a d	av				
		0 mg- One tablet twice					
		o mg- One tablet twice o mg- One tablet at nigl					
		dium 250 mg- Three ta					
	bedtime.	ululli 250 lilg- Tillee la	มเซเจ สเ				
	-Order dated 9/23/2	01.					
		ng- One tablet daily. ications were missing t	hair				
	•	ications were missing t	Hell				
	orders:	or One tablet deile					
		ng- One tablet daily.					
		ng- One tablet daily.					
) mcg- Instill 2 sprays ir	i each				
	nostril daily.	-II					
		dium 1 % gel- Apply to					
	affected area Four						
	-Hyaroxyzine 5	0 mg- Two tablets at be	eatime.				
	Observation on 0/0	0/04 at 11:10 are at 0!	opt #0!-				
		8/21 at 11:10 am of Cli	ent#ZS				
	medications reveal						
		te 10 mg- Medication v	vas not				
	available.	. 04 14					
		ge 81 mg- Medication w	as not				
	available.						
		edication was available					
		Medication was availa					
-Bupropion 40 mg- Medication was not available.			ailable.				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
					R		
		MHL032371	B. WING		09/28/2021		
	WITILU3237 I				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-						
	-Nullivitariiri- 9/25- -Tamsulosin 0.4 mg						
	-Docusate Sodium						
	-Glipizide 10 mg- 9						
	-Metformin 1000 mg- 9/25-9/28. -Atorvastatin 40 mg- 9/25-9/28.						
		g- 9/25-9/26. n 250 mg- 9/25-9/28.					
	-Jardiance 10 mg-						
	-Cetirizine 10 mg- 9						
	-Finasteride 5 mg-						
	-Fluticasone 50 mc						
		1 1 % gel- 9/25-9/28.					
	-Hydroxyzine 50 mg	y- 3120-3128.					
	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:			E 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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Division of Health Service Regulation

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	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 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 -Fish oil 1000 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. g- Medication was not - Medication was not available. dedication was not available. Medication was available. Medication was available. of Client #3's MARs for July ember 2021 revealed blanks tes: te 5 mg- 9/25-9/28. 81 mg- 9/25-9/28. g- 9/25-9/28.	V 118			
	revealed: -Staff at the home sure they complete	1 with the Program Manager were responsible for making d the MAR accordingly. at there were blanks on the				
	MARShe was aware the medications had ra	at some of the client's In out a few days ago.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			71. 501251110.		R		
		MHL032371		B. WING	<u> </u>		8/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	505 COOI DURHAM	K ROAD , NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	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 particle having the medicine and particle and particle having the medications. She was expecting to arrive at the house. She did not know we dates in August for a she acknowledged completed at the medications had be a she confirmed the medications were a she confirmed the current.	es refilled. It brought in the new It the client's new me Is by 3:00 pm today It the were also Client #3. It that the MAR was It that the MAR was It that the man the clie It is a client in the clie It is a client in the client	edications blank not being ent's ure tration.	V 118			
V 121	1 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	V 121 - The MedTechs for Rose's (the Program Manager and Owne obtained psychotropic drug review our pharmacist on Oct. 22, 2021 client. These reviews were placed each client's record book.	er) ws from for each		
	This Rule is not me Based on record re failed to obtain drug	views and interview	•				

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		
				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 RESIDENTIAL SERVICES INC 505 COO 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			
	three of three clients (#1, #2 and #3) who received psychotropic drugs. The findings are:						
	Review on 9/28/21 the following:	of Client #1's record	l revealed				
	-Admission date of						
		derline Intellectual Fu asive Developmenta					
	Recurrent Enuresis	s; Schizoaffective Dis					
	Intermittent Explosive DisorderPhysician's order dated 2/16/21: -Lorazepam 0.5 milligrams (mg,) One tablet						
		o tablets at noon; Tw	o tablets				
	at 4:00 pm; 1 Table	et at bedtime. enate 300 mg, One c	apsule in				
	the morning, Two o	capsules at night.	•				
) mg, Three tablets in					
		s, Four tablets at bed dium 250 mg, Three					
	-The July, August a	and September 2021					
		stration Record (MAI was administered th					
	-There was no evid	lence of a psychotro					
	review for Client #1's medications in the last six months.						
	Review on 9/28/21 the following:	of Client #2's record	l revealed				
	-Admission date of		M = 11:4				
	Type II; Schizoaffe	ertension; Diabetes l ctive Disorder;	vieilitus				
	Gastroesophageal	Reflux; Hyperlipiden	, ,				
	Hip Osteoarthritis; -Physician's order of	Dyslipidemia; Renal	Mass.				
		nna, Inject intramusc	ular every				
	four weeks.	•	•				
		mg, One tablet daily dium 250 mg, Three					

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		
			,		R	
		MHL032371	B. WING	<u> </u>		8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 121	needed for agitation -The July, August a Medication Adminis revealed Client #2 medications dailyThere was no evic review for Client #2 months. Review on 9/28/21 the following: -Admission date of -Diagnoses of Para Hypertension; Histo -Physician's order of -Citalopram 20 morningGabapentin 30 times a dayBenztropine 0Clozapine 50 r -The July, August a Medication Adminis revealed Client #3 medications dailyThere was no evid review for Client #3 months. Interview on 9/28/2 revealed: -She was not award for psychotropic medications dailyShe would have pl psychotropic medications completedShe would have pl psychotropic medications confirmed the	mg, One tablet twice a day as a. 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. anoid Schizophrenia; bry of Alcohol Abuse. dated 8/20/20: mg, One tablet in the 20 mg, One capsule three 25 mg, One tablet twice a day. mg, Three tablets at bedtime. and September 2021 stration Record (MAR) was administered the above ence of a psychotropic drug l's medications in the last six 1 with the Program Manager et that 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.