STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601464	A. BUILDING: _____ B. WING _____	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROPES, INC	10721 GLENLUCE AVENUE CHARLOTTE, NC 28213

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on August 30, 2022. The complaint was substantiated (Intake # NC 00189699). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities. The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement written policies regarding discharge affecting 1 of 1 former client (Former Client #3 (FC #3)). The findings are:

Review on 7/27/22 of the facility's discharge policy revealed:
-The Discharge/Transfer Policy was embedded within the undated ROPES (facility) Residential Client Manual Handbook and House Rules;
-"ROPES Group Home offers appropriate services to its residents, to enable them to become contributing members of society. We are aware at all times of the individual needs and community resources available for each resident's community placement. Discharge Planning which clearly defines these needs will be entered into each resident's permanent record and reviewed annually. The decision to discharge will be recommended by the interdisciplinary team and reviewed annually ...At the time of permanent release or transfer, there will be recorded a summary of the following information: Findings, event in progress during the period of service to the individual; resident's progress made during enrollment in the home; specific recommendations and arrangements for future programs and follow-up services; group home's evaluation of the appropriateness of the reason for terminating services ..."

Review on 7/27/22 of FC#3's record revealed:
-Admitted 11/8/21;
-Discharged 5/17/22;

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V 105	Continued From page 3 -17 years old; -Diagnosed with Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder; -No documentation of discharge planning which clearly defined FC#3's needs; -No documentation of specific recommendations and arrangements for future programs and follow-up services. Attempted interview 7/25/22 with FC#3 was unsuccessful. A phone call placed to FC#3's cell phone was unanswered. A voicemail could not be left as no voicemail had been set up. A text message sent to the number was unanswered. Interview on 7/27/22 with FC#3's Mother/Legal Guardian revealed: -FC#3 was brought to his Grandfather's home by Executive Director/Qualified Professional (ED/QP) after he revealed he "could not do this (care for FC#3) anymore." Interview on 7/28/22 with FC#3's Grandfather revealed: -ED/QP loaded FC#3's belongings into the vehicle sometime after midnight on 5/14/22 and drove FC#3 over 3 hours to his home; -Was informed by FC#3's Mother/Legal Guardian that FC#3 was being driven to his home; -FC#3's Mother/Legal Guardian learned that FC#3 was on his way to his Grandfather's home during a telephone call with FC#3; -He waited up through the night waiting for ED/QP to arrive with FC#3; -As hours passed, he began to worry and was preparing to leave to go look for ED/QP and FC#3 when he spotted the headlights on his driveway; -He went out to the front porch and watched ED/QP and FC#3 arrive shortly after 6am on the	V 105		

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V 105	Continued From page 4	V 105		

morning of 5/14/22;
-ED/QP unpacked FC#3's belongings and placed them on the front porch and drove away leaving FC#3;
-ED/QP did not provide paperwork or an explanation of the sudden unplanned discharge;
-He did not engage in a verbal exchange with ED/QP as he did not want to initiate any "unnecessary problems;"
-Was given one week of medication for FC#3.

Interview on 7/27/22 with the House Manager revealed:
-Was not involved in FC#3's discharge;
-FC#3 was taken to his Grandfather's home by the ED/QP "near the beach" because "he had been given notice that he needed to leave by 5/21/22 when he turned 18."

Interviews on 7/27/22 and 8/4/22 with the ED/QP revealed:
-The policies were not stored in the facility but were stored in the office and he would provide a copy of the policy when he returned to the office;
-The policies were included in the ROPES (facility) Residential Client Manual Handbook and House Rules;
-FC#3's behaviors escalated in intensity and frequency starting 4/6/22 and lasting until discharge;
-FC#3 required law enforcement intervention and emergency psychiatric consultation during period 4/6/22 until he was brought to his Grandfather's home on 5/14/22;
-FC#3 engaged in an extensive behavioral outburst on 5/13/22 which lasted for hours resulting in emergency psychiatric consultation, released back to the facility, and continued defiance and threats toward staff past midnight on 5/14/22;

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V 105	Continued From page 5 -FC#3 was discharged to his Grandfather's care during a sudden unannounced visit to FC#3's Grandfather's home in the early morning hours of 5/14/22 after traveling over 3 hours; -FC#3's official date of discharge from the facility was 5/17/22 despite being taken to his Grandfather's home on 5/14/22; -The discharge policy was not followed to include specific recommendations and arrangements for future programs and follow up services because the situation on 5/13/22-5/14/22 "got out of hand with [FC#3]'s behavior;" -During the exit conference, he did not wish to make any comments and revealed: "let's just go over it all (deficiencies)."	V 105		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 109		

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V 109	Continued From page 6 (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 audited Qualified Professional (Executive Director/Qualified Professional (ED/QP)) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 7/27/22 of the ED/QP's record revealed: -Hired 11/8/21. Refer to V112 for failure to develop and implement treatment strategies to address client needs: -ED/QP did not develop strategies to address FC#3's educational needs; -ED/QP did not develop new strategies to address FC#3's continued behavioral outbursts.	V 109		

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V 109	Continued From page 7 Refer to V368 for failure to ensure continuity of care: -ED/QP did not ensure continuity of care for FC#3 after a sudden unplanned discharge from the facility to his Grandfather's home; -ED/QP did not notify FC#3's county of the intent to discharge at least 60 days prior to discharge. Interviews on 7/27/22, 7/28/22, and 8/4/22 with the ED/QP revealed: -He identified himself as the primary qualified professional responsible for overseeing the facility, client treatment, coordination of care, admission and discharges, and staff supervision; -FC#3 refused to return to the alternative school and there was nothing further facility staff could do regarding the matter; -Did not complete any further follow up with educational services to have FC#3 re-enrolled in the alternative school or develop services through the county's public school system; -Did not develop treatment strategies to assist FC#3 with continuing his education; -Did not develop new treatment strategies to assist FC#3 with controlling his angry outbursts; -FC#3 was discharged to his Grandfather's care during a sudden unannounced visit to FC#3's Grandfather's home in the early morning hours of 5/14/22 traveling over 3 hours; -During the exit conference, he did not wish to make any comments and revealed: "let's just go over it all (deficiencies)." This deficiency is cross-referenced into 10A NCAC 27G .5601 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 112		

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V 112	Continued From page 8 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement treatment strategies to address the needs for 1 of 1 former client (Former Client #3 (FC#3)). The findings are:	V 112		

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V 112	Continued From page 9 Review on 7/27/22 of FC#3's record revealed: -Admitted 11/8/21; -Discharged 5/17/22; -17 years old; -Diagnosed with Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder; -Admission assessment dated 11/2021 revealed: loses temper easily, verbal threats toward others, stealing, running away, self-harm, property destruction, and assault; -Treatment plan dated 4/6/22 included goals to: " ...reduce the intensity and frequency of all types of angry behaviors by identifying and expressing early warning signs of anger or hostility...will verbalize an understanding of the benefits for self and others of living within the laws and rules of society ...develop the essential social skills that will enhance the quality of relationship life by describing the history and nature of social fears and avoidance ...develop the ability to form at least 2 positive relationships that will enhance recovery support;" -Treatment plan progress updates dated 4/6/22 and 5/12/22 included: " ...increased the intensity and frequency of negative behaviors over the past week and has begun cycling downward ...anger peaked ...breaking into the office with stolen keys and scratched staff with a key when confronted ...decreasing angry outbursts is minimal ...has a hard time communicating his thoughts in a coherent manner and in a way in which he can receive feedback that can correct his behaviors ...became verbally and physically aggressive ...continues to display rule breaking behaviors when upset and violent aggression when limits are set ..." -Undated discharge notice written by the Executive Director/Qualified Professional (ED/QP) revealed FC#3 engaged in behaviors	V 112		

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including attempting to steal a staff car and assaulting staff on 5/6/22 and threatened to jump out of a moving vehicle and jump off a parking garage on 5/7/22;
-No strategies to assist FC#3 with continuing his education and no new strategies to assist with controlling his angry outbursts.

Interview on 7/27/22 with FC#3's Mother/Legal Guardian revealed:
-Agreed to FC#3's placement at the facility because she "believed it was a high-level clinical program;"
-Was disappointed in the services her son received from the facility.

Attempted interview 7/25/22 with FC#3 was unsuccessful. A phone call placed to FC#3's cell phone was unanswered. A voicemail could not be left as no voicemail had been set up. A text message sent to the number was unanswered.

Interviews on 7/27/22, 7/28/22, and 8/4/22 with the ED/QP revealed:
-FC#3 was expelled from one school after being arrested for assault on a school official and a law enforcement officer in February, 2022;
-FC#3 attended a second school which was an alternative school for two days and was engaged in an altercation with a school official, was suspended, and refused to return;
-FC#3 was not accepted into home bound education;
-Did not develop treatment strategies to assist FC#3 with continuing his education;
-Did not develop new treatment strategies to assist FC#3 with controlling his angry outbursts;
-FC#3 refused to return to the alternative school and there was nothing further facility staff could do regarding the matter;

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V 112	Continued From page 11 -FC#3 "wanted to drop out of school ...he went to school in order to get thrown out of school;" -During the exit conference, he did not wish to make any comments and revealed: "let's just go over it all (deficiencies)." This deficiency is cross-referenced into 10A NCAC 27G .5601 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on review record and interview, the facility failed to ensure fire and disaster drills were held quarterly and repeated for each shift. The findings are: Review on 7/27/22 of facility's fire and disaster drills revealed:	V 114		

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V 114	Continued From page 12 -Fourth Quarter (October - December), 2021: No 3rd shift fire and disaster drills; -First Quarter (January - March), 2022: No 1st and 3rd shift fire and disaster drills; -Second Quarter (April - June), 2022: No 1st and 2nd shift fire and disaster drills; -Third Quarter (July - September), 2022: No 1st and 3rd shift fire and disaster drills. Interview on 7/27/22 with Client #1 revealed: -No fire and disaster drills completed since admission (7/13/22) yet but knows to "run outside" for a fire and "didn't think we get tornadoes here." Interview on 7/28/22 with Client #2 revealed: -Staff helps them complete fire drills; -"We did one today." Interview on 7/27/22 with Staff #3 revealed: -Completed fire and disaster drills when instructed to do so by Executive Director/Qualified Professional (ED/QP); -Evacuation signs are also posted throughout the facility. Interviews on 7/28/22 and 8/4/22 with ED/QP revealed: -3 shifts: 1st shift (6am-2pm), 2nd shift (2pm-10pm), 3rd shift (10pm-6am); -Informed staff when drills were due; -Instructed staff to complete drills; -During the exit conference, he did not wish to make any comments and revealed: "let's just go over it all (deficiencies)."	V 114		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 116		

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V 116	Continued From page 13 REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by:	V 116		

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V 116	Continued From page 14 Based on record review, interview, and observation, the facility failed to ensure medication dispensing was restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 2 of 2 audited clients (Clients #1 and #2). The findings are: Review on 7/27/22 of Client #1's record revealed: -Admitted 7/13/22; -13 years old; -Diagnosed with Autism Spectrum Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder. Review on 7/27/22 of Client #2's record revealed: -Admitted 10/15/21; -15 years old; -Diagnosed with Persistent Depressive Disorder, Conduct Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder. Observation on 7/27/22 at approximately 2:06pm of Client #1's medications revealed: -Pill box with compartments labeled morning, noon, and night with pills inside the compartments for 7 days. Refer to V118 for information regarding medication orders and observations of medications for each client. Interviews on 7/27/22 and 8/4/22 with the Executive Director/Qualified Professional revealed: -He removed the clients pills from the pharmacy pill bottles and placed them in the pill boxes on a weekly basis;	V 116		

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V 116	Continued From page 15 -Staff administered medications by using the pill boxes; -Client #2 was on a home visit with his pill box with compartments labeled morning, noon, and night with medications inside the compartments from the pill bottles; -Was not aware the use of pill boxes was considered dispensing; -Will no longer use pill boxes. This deficiency is crossed referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 116		
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;	V 118		

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V 118	Continued From page 16 (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. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure medications were administered on the written order of a physician and the MAR for each client was kept current affecting 2 of 2 audited clients (Clients #1 and #2). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Administration (V116) Based on record review, interview, and observation, the facility failed to ensure medication dispensing was restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 2 of 2 audited clients (Clients #1 and #2). Review on 7/28/22 of the ROPES (facility) Residential Client Manual Handbook and House Rules revealed: -"ROPES (facility) staff does not 'administer' any medication (page 6)."	V 118		

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V 118	Continued From page 17 Review on 7/27/22 of Client #1's record on revealed: -There were no signed physician orders in the facility; -July, 2022 MAR revealed administration of: -Clonidine HCL ER (Extended Release) (attention) 0.1 mg (milligrams) 2 tabs (tablets) daily at 4pm; -Clonidine HCL 0.1mg 1 tab daily at 8am; -Trazodone HCL (sleep) 50mg 1 tab daily at 8pm; -Risperidone (irritability) 0.1mg 1.5 tabs daily at 8am; -No documentation of medication administration for all medication on 7/26/22 and for morning medications on 7/27/22 (reviewed at approximately 2pm on 7/27/22). Interview on 7/27/22 with Client #1 revealed: -Staff administered his medications and he "just takes them (medications);" -Could not identify if he ever missed medication administration. Interview on 7/28/22 with Client #1's pharmacy revealed: -Client #1's medication orders were for: -Clonidine HCL ER 0.1mg 1 tablet every morning and 2 tablets every day at 4pm; -Clonidine HCL 0.1mg 1 tablet at bedtime; -Trazodone 50mg 1 tablet at bedtime as needed; -Risperidone 1mg 1 ½ tablets every morning and 1 tablet at bedtime. Observation on 7/27/22 at approximately 2:06pm of Client #1's medications revealed the following medications dispensed on 7/1/22: -Clonidine HCL ER 0.1mg 1 tab every morning and 2 tabs at 4pm;	V 118		

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V 118	Continued From page 18 -Clonidine HCL 0.1mg 1 tab at bedtime; -Trazodone HCL 50mg 1 tab at bedtime as needed; -Risperidone 1mg 1.5 tabs every morning and 1 tab at bedtime. Review on 7/27/22 of Client #2's record revealed: -Physician's orders dated 4/6/22 and 7/18/22 for Tegretol (mood) 200mg 1 tab twice daily at 8am and 8pm; -July, 2022 MAR revealed no documentation of administration of Tegretol 200mg 1 tab daily at 8pm for the entire month as there was no transcription for the 8pm dose. Interview on 7/28/22 with Client #2 revealed: -Staff administered his medications. Observation on 7/27/22 at approximately 12:47pm of Client #2's medications revealed: -Bottle of Tegretol 200mg 60 tabs dispensed on 7/1/22 with pharmacy label directions of 1 tab twice daily with 26 pills remaining in the bottle. Interview on 7/27/22 with Staff #3 revealed: -Did not identify any omissions regarding location to document medication administration on each client's MARs. Interview and observation on 7/27/22 at approximately 1:45pm with the Executive Director/Qualified Professional (ED/QP) revealed: -Received verbal orders from the pharmacy on Client #1's date of admission; -An email on his cell phone from the dispensing pharmacy with a list of Client #1's medications; -Had previously contacted the physician to receive copies of Client #1's medication orders; -Client #2's MAR notation of Tegretol 200mg 1 tab daily was an error and should have indicated	V 118		

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administration of Tegretol 200mg 1 tab twice daily;
-Client #2's Tegretol error was a documentation error and not an administration error;
-Client #2's Tegretol had been administered twice daily at 8am and 8pm;
-Was unable to identify why 26 Tegretol tabs remained in the bottle on 7/27/22 considering 60 tabs were dispensed on 7/1/22 with directions for administration of 1 tab twice daily;
-All medications were administered accurately.

Due to failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

Review on 8/4/22 of the first Plan of Protection completed by the ED/QP dated 8/3/22 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Review Medication Orders and align with MAR Forms [complete 8/2]
-Do not use pill boxes instead use bottle or blister packs [effective immediately 8/1]
-Keep current Med (medication) Administration training for all staff.
-Have MAR current for each day.

Describe your plans to make sure the above happens.
-Create/Review MAR each month to make sure it is aligned with doctors orders.
-Do not give clients med from pill box.
-Use blister pack or give from bottle.
-Make sure MAR is current for each day.
-[House Manager (HM)] will oversee the process."

Review on 8/8/22 of the second Plan of Protection completed by the ED/QP dated 8/6/22

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revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Ropes (facility) staff will review each consumer medication order and align with the MAR Forms [completed 7/28].

Describe your plans to make sure the above happens:
-Check each MAR form against signed medication service order each month as a two-step process. Lead QP (ED/QP) will sign off on form completed by team lead (HM) each month to make sure orders are aligned. [completed 8/1]
-Ropes will create a training around creating/reviewing the MAR Forms and have employees sign for understanding. [Will be completed by 8/19]
-Ropes staff will not give clients medication from pill box. Ropes will instead use blister packs or bottle when giving out meds. [Completed 7/28]
-Ropes staff will ensure that the MAR Form is correct for each day. [Completed 7/28]
-Team lead [HM] will oversee the process."

Clients #1 and #2 were 13-15 years old with diagnoses which included Autism Spectrum Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Persistent Depressive Disorder, Conduct Disorder, and Disruptive Mood Dysregulation Disorder. Clients #1 and #2 were prescribed medications to assist with their mental health needs and were dependent upon facility staff for medication administration. There were no signed medication orders in the facility for Client #1. The July, 2022 MAR revealed inaccuracies with administration directions for Clonidine HCL ER, Clonidine HCL, Trazodone HCL, and Risperidone. Client #2 was

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V 118	Continued From page 21 not administered his Tegretol 200mg at 8pm for the entire month of July, 2022. There were still 26 tabs of Client #2's Tegretol on 7/27/22 despite 60 tabs being dispensed on 7/1/22 with orders to administer twice daily. Furthermore, the pill boxes were used for Clients #1 and #2 with ED/QP dispensing medications into the pill boxes weekly. This deficiency a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to an offer of employment affecting 1 of 3 audited staff (Staff #3). The findings are:	V 131		

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V 131	Continued From page 22 Review of Staff #3's record revealed: -Hired 11/8/2021; -HCPR dated 11/14/2021. Interviews on 7/27/22 and 8/4/22 with the Executive Director/Qualified Professional revealed: -He may have an additional HCPR report prior to 11/14/21 and would provide it if he could locate it; -Was unable to locate a previous HCPR report on Staff #3; -During the exit conference, he did not wish to make any comments and revealed: "let's just go over it all (deficiencies)."	V 131		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which	V 289		

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V 289	Continued From page 23 serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289		

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V 289	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide services in the care, habilitation, or rehabilitation of individuals who have a developmental disability affecting 1 of 1 former client (Former Client #3 (FC#3)). The findings are: CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interview, 1 of 1 audited Qualified Professional (Executive Director/Qualified Professional (ED/QP)) failed to demonstrate the knowledge, skills, and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interview, the facility failed to develop and implement treatment strategies to address the needs of the clients affecting 1 of 1 former client (Former Client #3 (FC#3)). CROSS REFERENCE: General Statute 112C-63 Assurance for Continuity of Care for Individuals with Mental Retardation (V368) Based on record review and interview, the facility failed to ensure continuity of care in an alternative facility when the original facility could no longer provide the necessary care and failed to notify the area authority serving the client's county of residence of the intent to discharge a client who was in need of continuing care at least 60 days prior to discharge affecting 1 of 1 former client (Former Client #3 (FC#3)).	V 289		

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V 289	Continued From page 25 Review on 8/4/22 of the first Plan of Protection completed by the ED/QP dated 8/3/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Ensure a continuity of care plan Describe your plans to make sure the above happens. -We will give 30 day notice letter in writing for future discharges. [effective immed (immediately)] -Work with care coordinator to secure placement/service coordination for continued care and continuity. -Document any refusals or attempts to coordinate/follow up with care." Review on 8/29/22 of the second Plan of Protection completed by the ED/QP dated 8/29/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Qualified professionals with Ropes (facility) will be thoroughly screened and trained. Competence shall be demonstrated by exhibiting core skills including technical knowledge; cultural awareness; analytical skills; decision-making; interpersonal skills; communication skills; and clinical skills. Qualified professionals will also be screened for appropriate background experience and education. Describe your plans to make sure the above happens. Train staff with our 17 Core trainings and ensure annual and monthly supervision plans." Review on 8/29/22 of the third Plan of Protection completed by the ED/QP dated 8/29/22 sent in email format as opposed to the use of the	V 289		

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V 289	Continued From page 26 Division of Health Service Regulation form revealed: "Our plan of protection includes a mandatory review of client person plan when behaviors escalate. Each QP (qualified professional) assigned to the client will be assigned to staff and review person centered plan with supervisor to see if interventions need to be added or adjusted. Ropes will ensure that each client is notified of discharge procedures within 60 days of discharge. Ropes has updated client manual and policies to reflect these changes." Review on 8/30/22 of the fourth Plan of Protection completed by the ED/QP dated 8/29/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Our plan for protection includes a mandatory review of client person plan when behaviors escalate. Each QP assigned to the client will be trained to review person centered plan with supervisor, as needed, to see if interventions need to be added or adjusted. Ropes will also ensure that each client is notified of discharge procedures within 30 days of discharge. Ropes will coordinate discharge with appropriate stakeholders including care coordinators and client family/guardian to ensure continuity of care. Ropes will ensure each client has smooth transition of care to next level of service. Ropes has updated client manual and policies to reflect these changes. Describe your plans to make sure the above happens. Ropes plans to review the PCP (person centered plans) each time an incident or significant change occurs with a client. Ropes will staff each escalation with supervisor and lead QP along with	V 289		

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V 289	Continued From page 27	V 289		

pertinent stakeholders to ensure changes are made when necessary. Ropes will be sure each client and stakeholder is informed of discharge process and notification will be sent out immediately with intent to discharge from services. Ropes will notify, in writing, all pertinent stakeholders to inform of discharge status and options for continuity of care. Ropes will ensure access to Policy and Procedures for all stakeholders."

FC#3 was 17 years old and was diagnosed with Autism Spectrum Disorder and Disruptive Mood Dysregulation Disorder. He had a history of losing his temper easily, verbal threats toward others, stealing, running away, self-harm, property destruction, and assault. FC#3 was suspended and/or expelled from two school settings due to assaulting school officials and law enforcement. ED/QP did not coordinate educational services and did not develop and implement treatment strategies to address such services. FC#3's aggressive and angry outbursts increased in intensity and severity, but ED/QP did not develop and implement new treatment strategies to address the behaviors. ED/QP discharged FC#3 from the facility during a sudden unplanned trip to FC#3's Grandfather's home traveling over 3 hours in the middle of the night and left FC#3 on the front porch of the home with only one week of medications and no paperwork. Continuity of care was not maintained for FC#3 due to the manner of the sudden unplanned discharge. ED/QP was responsible for overseeing the facility, client treatment, coordination of care, admissions and discharges, and staff supervision, but he failed to ensure discharge procedures were followed as required. This deficiency constitutes a Type A1 rule violation for serious neglect and must be

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V 289	Continued From page 28 corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required	V 367		

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report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;

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V 367	Continued From page 30 (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure level ll incidents were reported to the local management entity within 72 hours of becoming aware of the incident. The findings are: Review on 7/27/22 of Former Client #3 (FC #3's) record revealed: -Admitted 11/8/22; -Discharged 5/17/22; -17 years old; -Diagnosed with Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder; -Undated discharge notice written by the Executive Director/Qualified Professional (ED/QP) revealed FC#3 engaged in behaviors including attempting to steal a staff car and assaulting staff on 5/6/22 and threatened to jump out of a moving vehicle and jump off a parking garage on 5/7/22.	V 367		

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V 367	Continued From page 31 Review on 7/27/22 of the facility's Incident Reports for period 5/1/22-7/27/22 revealed: -No Level II incident reports completed for FC#3. Interview on 7/28/22 with law enforcement revealed: -Request for law enforcement assistance during a welfare check for FC#3 on 5/14/22. Interviews on 7/27/22 and 8/4/22 with the ED/QP revealed: -Believed all level 2 incident reports were completed in North Carolina Incident Response Improvement System (NC IRIS); -FC#3 had significant behavioral issues including reports to law enforcement in May, 2022 prior to discharge; -Would follow up with NC IRIS staff to ensure all incident reports were completed and submitted properly; -During the exit conference, he revealed he spoke with someone at NC IRIS to ensure proper completion and submission of all incident reports.	V 367		
V 368	G.S. 122C-63 Assurance for continuity of care § 122C-63 ASSURANCE FOR CONTINUITY OF CARE FOR INDIVIDUALS WITH MENTAL RETARDATION (a) Any individual with mental retardation admitted for residential care or treatment for other than respite or emergency care to any residential facility operated under the authority of this Chapter and supported all or in part by state-appropriated funds has the right to residential placement in an alternative facility if the client is in need of placement and if the original facility can no longer provide the necessary care or treatment.	V 368		

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V 368	Continued From page 32 (b) The operator of a residential facility providing residential care or treatment, for other than respite or emergency care, for individuals with mental retardation shall notify the area authority serving the client's county of residence of his intent to close a facility or to discharge a client who may be in need of continuing care at least 60 days prior to the closing or discharge. The operator's notification to the area authority of intent to close a facility or to discharge a client who may be in need of continuing care constitutes the operator's acknowledgement of the obligation to continue to serve the client until: (1) The area authority determines that the client is not in need of continuing care; (2) The client is moved to an alternative residential placement; or (3) Sixty days have elapsed; whichever occurs first. In cases in which the safety of the client who may be in need of continuing care, of other clients, of the staff of the residential facility, or of the general public, is concerned, this 60- day notification period may be waived by securing an emergency placement in a more secure and safe facility. The operator of the residential facility shall notify the area authority that an emergency placement has been arranged within 24 hours of the placement. The area authority and the Secretary shall retain their respective responsibilities upon receipt of this notice. (c) An individual who may be in need of continuing care may be discharged from a residential facility without further claim for continuing care against the area authority or the State if: (1) After the parent or guardian, if the client is a minor or an adjudicated incompetent adult, or the client, if an adult not adjudicated incompetent,	V 368		

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V 368	Continued From page 33 has entered into a contract with the operator upon the client's admission to the original residential facility the parent, guardian, or client who entered into the contract refuses to carry out the contract, or (2) After an alternative placement for a client in need of continuing care is located, the parent or guardian who admitted the client to the residential facility, if the client is a minor or an adjudicated incompetent adult, or the client if an adult not adjudicated incompetent, refuses the alternative placement. (d) Decisions made by the area authority regarding the need for continued placement or regarding the availability of an alternative placement of a client may be appealed pursuant to the appeals process of the area authority and subsequently to the Secretary or the Commission under their rules. If the appeal process extends beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange a temporary placement in a State facility for the mentally retarded pending the outcome of the appeal. (e) The area authority that serves the county of residence of the client is responsible for assessing the need for continuity of care and for the coordination of the placement among available public and private facilities whenever the authority is notified that a client may be in need of continuing care. If an alternative placement is not available beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange for a temporary placement in a State facility for the mentally retarded. The area authority shall retain responsibility for coordination of placement during a temporary placement in a State facility. (f) The Secretary is responsible for	V 368		

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V 368	Continued From page 34 coordinative and financial assistance to the area authority in the performing of its duties to coordinate placement so as to assure continuity of care and for assuring a continuity of care placement beyond the operator's 60-day obligation period. (g) The area authority's financial responsibility, through local and allocated State resources, is limited to: (1) Costs relating to the identification and coordination of alternative placements; (2) If the original facility is an area facility, maintenance of the client in the original facility for up to 60 days; and (3) Release of allocated categorical State funds used to support the care or treatment of the specific client at the time of alternative placement if the Secretary requires the release. (h) In accordance with G.S. 143B-147(a)(1) the Commission shall develop programmatic rules to implement this section, and, in accordance with G.S. 122C-112(a)(6), the Secretary shall adopt budgetary rules to implement this section. (1981, c. 1012; 1985, c. 589, s. 2.) This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure continuity of care in an alternative facility when the original facility could no longer provide the necessary care and failed to notify the area authority serving the client's county of residence of the intent to discharge a client who	V 368		

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was in need of continuing care at least 60 days prior to discharge affecting 1 of 1 former client (Former Client #3 (FC#3)). The findings are:

Review on 7/27/22 of FC#3's record revealed:
-Admitted 11/8/21;
-Discharged 5/17/22;
-17 years old;
-Diagnosed with Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder;
-Admission assessment dated 11/2021 revealed: loses temper easily, verbal threats toward others, stealing, running away, self-harm, property destruction, and assault;
-No documentation of contact to the county of residence for intent to discharge 60 days prior to discharge.

Attempted interview 7/25/22 with FC#3 was unsuccessful. A phone call placed to FC#3's cell phone was unanswered. A voicemail could not be left as no voicemail had been set up. A text message sent to the number was unanswered.

Interview on 7/27/22 with FC#'s Mother/Legal Guardian revealed:
-FC#3 was dropped at his Grandfather's home after Executive Director/Qualified Professional (ED/QP) revealed he "could not do this (care for FC#3) anymore" after several hours into FC#3's behavioral outburst on 5/13/22-5/14/22;
-FC#3 informed his mother that he was being transported to his Grandfather's home.

Interview on 7/28/22 with FC#3's Grandfather revealed:
-ED/QP loaded FC#3's belongings into the vehicle sometime after midnight on 5/14/22 and drove FC#3 over 3 hours away to his home;
-ED/QP and FC#3 arrived at his home shortly

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V 368	Continued From page 36 after 6am on the morning of 5/14/22; -ED/QP unpacked FC#3's belongings and placed them on the front porch and drove away leaving FC#3; -ED/QP did not provide an explanation of the sudden unplanned discharge; -ED/QP left FC#3 on the front porch with only one week of medications and no paperwork. Interviews on 7/28/22 and 8/4/22 with the ED/QP revealed: -Had discussed discharge with FC#3's mother/legal guardian and care coordinator during monthly meetings; however, no formal or definite discharge plans were made; -FC#3 was discharged to his Grandfather's care during a sudden unannounced visit to FC#3's Grandfather's home in the early morning hours of 5/14/22 traveling over 3 hours; -During the exit conference, he did not wish to make any comments and revealed: "let's just go over it all (deficiencies)." This deficiency is cross-referenced into 10A NCAC 27G .5601 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 368		
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 maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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V 736	Continued From page 37 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: Observation on 7/27/22 at approximately 12pm of the facility revealed: -Grass was between 2 to 4 feet high in areas in the front, side, and rear yards; -Downstairs entry hallway and bathroom had patches of unpainted sheetrock. Interview on 7/27/22 with the Executive Director/Qualified Professional revealed: -"The lawn was mowed last week ...the person who mows the lawn is not here right now;" -"There is no gas to mow the lawn;" -"The wall in the bathroom has to be painted because the towel rack just fell down."	V 736		