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 _____	R 11/10/2022

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ROPES, INC	10721 GLENLUCE AVENUE CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on November 10, 2022. The complaint was substantiated (Intake #NC00193959). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION 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	V 116		

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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:
Based on interview, record review, and observation, the facility failed to ensure medication dispensing was restricted to registered pharmacists, physicians, or other health practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 3 of 3 clients (Client #1, #2, and #3). The findings are:

Review on 10/24/22 of Client #1's record revealed:
-Admitted 7/16/22;
-Diagnosed with Autism Spectrum Disorder, Mild Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD);
-18 years old;
-Physician's orders dated 7/22/22 for:
-Guanfacine (ADHD) 4 milligrams (mg) 1 tablet (tab) each morning;
-September and October, 2022 MARs revealed administration of Guanfacine 4 mg 1 tab daily at 8am, with the exception of 10/24/22 for which

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V 116	Continued From page 2 there was no documentation of administration. Review on 10/24/22 of Client #2's record revealed: -Admitted 8/29/22; -Diagnosed with Autism Spectrum Disorder, ADHD, DMDD, Moderate Intellectual Developmental Disability, Schizophrenia; -10 years old; -No medication orders; -Undated demographic face sheet with no electronic or physical physician's signature revealed medications as: -Prazosin (urinary retention) 1mg caplet (cap); -Guanfacine (ADHD) 2mg tab; -Strattera (ADHD) 25mg cap; -No dose or administration directions noted; -September and October, 2022 MARs revealed administration of: -Prazosin 1mg 1 cap daily at 8pm; -Guanfacine 2mg 1 tab twice daily at 8am and 8pm; -Atomoxetine HCl 25mg 1 cap daily at 8am. Review on 10/24/22 of Client #3's record revealed: -Admitted 11/8/21; -Diagnosed with DMDD, Conduct Disorder, Persistent Depressive Disorder, Autism Spectrum Disorder; -15 years old; -Physician's orders dated 7/18/22 for: -Aripiprazole (antipsychotic) 10mg 1 tab each morning; -Concerta (ADHD) 27mg 1 tab each morning; -Nortriptyline HCl (antidepressant) 25mg 1 cap each evening; -Clonidine HCl 0.1mg (ADHD) 1 tab each evening;	V 116		

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V 116	Continued From page 3 -Tegretol 200mg (mood) 1 tab twice daily in the morning and evening; -September and October, 2022 MARs revealed administration of: -Aripiprazole 10mg 1 tab daily at 8am; -Concerta 27mg 1 tab daily at 8am; -Nortriptyline HCl 25mg 1 cap daily at 8pm; -Clonidine HCl 0.1mg 1 tab daily at 8pm; -Tegretol 200mg 1 tab twice daily at 8am and 8pm. Observation on 10/24/22 at approximately 10:20am-10:40am of Client #1, #2, and #3's medications revealed: -Weekly blister packs with no packaging label(s) of each prescription medication including the prescriber's name, the current dispensing date, clear directions for administration, the name, strength, quantity and expiration date of the prescribed medication, the name, address, and phone number of the pharmacy or dispensing location or the name of the dispensing practitioner attached to the blister packs. Various medications in the blister packs for Clients #2 and #3. Client #1's blister pack was empty. Each client's name was hand-written in black marker on the cardboard blister packaging. Interview on 10/24/22 with Staff #1 revealed: -The Licensee/Executive Director/Qualified Professional (L/ED/QP) received the medications from the pharmacy and then blister packed the medications himself; -Was unable to identify what medication was in each blister pack bubble; -Identified the clients were receiving their prescribed medications as ordered by the physician but was unable to identify how he could ensure this and stated: "Come on, you can't ask me how I know that."	V 116		

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V 116	Continued From page 4 Interview on 10/24/22 and 11/9/22 with the L/ED/QP revealed: -Received medications from the pharmacy, removed the medications from the pharmacy bottles, and then blister packed the medications himself to make it easier for staff to administer the medications; -Ordered the empty blister packs from the internet; -Was unable to identify what medication was in each blister pack bubble and revealed: "I just know that they are right (correct medications for each client);" -Would call the pharmacist and see if the medications could be blister packed by the pharmacist in the future; -The pharmacy blister packed clients' medications for a small additional fee. Interview on 10/25/22 with the Pharmacist revealed: -Dispensed medications for Clients #1, #2, and #3 in September and October, 2022; -Was able to blister pack medications if the customer requested; -The L/ED/QP never requested medications blister packed for Clients #1, #2, and #3; -Was not certain she could correctly identify multiple medications once they were removed from the labeled pharmacy dispensed bottles as many medications look similar; -"It would be hard for me as a pharmacist (to correctly identify the medications), especially since there are so many differences with generics (medications)." This deficiency constitutes a recited deficiency. This deficiency is cross referenced into 10A	V 116		

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V 116	Continued From page 5 NCAC 27G .0209 Medication Requirements (V118) for a Failure to Correct Type A1 rule violation.	V 116		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 6 This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure medications were maintained with packaging labels affecting 3 of 3 clients (Clients #1, #2, and #3). The findings are: Review on 10/24/22 of Client #1's record revealed: -Admitted 7/16/22; -Diagnosed with Autism Spectrum Disorder, Mild Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD); -18 years old; -Physician's orders dated 7/22/22 for: -Guanfacine (attention) 4 milligrams (mg) 1 tablet (tab) each morning; -September and October, 2022 MARs revealed administration of Guanfacine 4 mg 1 tab daily at 8am, with the exception of 10/24/22 for which there was no documentation of administration. Review on 10/24/22 of Client #2's record revealed: -Admitted 8/29/22; -Diagnosed with Autism Spectrum Disorder, ADHD, DMDD, Moderate Intellectual Developmental Disability, Schizophrenia; -10 years old; -No medication orders; -Undated demographic face sheet with no electronic or physical physician's signature revealed medications as: -Prazosin (urinary retention) 1mg caplet (cap); -Guanfacine (attention) 2mg tab; -Strattera (attention) 25mg cap; -No dose or administration directions noted	V 117		

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-September and October, 2022 MARs revealed administration of:
-Prazosin 1mg 1 cap daily at 8pm;
-Guanfacine 2mg 1 tab twice daily at 8am and 8pm;
-Atomoxetine HCl 25mg 1 cap daily at 8am.

Review on 10/24/22 of Client #3's record revealed:
-Admitted 11/8/21;
-Diagnosed with Disruptive Mood Dysregulation Disorder, Conduct Disorder, Persistent Depressive Disorder, Autism Spectrum Disorder;
-15 years old;
-Physician's orders dated 7/18/22 for:
-Aripiprazole (antipsychotic) 10mg 1 tab each morning;
-Concerta (attention) 27mg 1 tab each morning;
-Nortriptyline HCl (antidepressant) 25mg 1 cap each evening;
-Clonidine HCl 0.1mg (attention) 1 tab each evening;
-Tegretol 200mg (mood) 1 tab twice daily in the morning and evening;
-September and October, 2022 MARs revealed administration of:
-Aripiprazole 10mg 1 tab daily at 8am;
-Concerta 27mg 1 tab daily at 8am;
-Nortriptyline HCl 25mg 1 cap daily at 8pm;
-Clonidine HCl 0.1mg 1 tab daily at 8pm;
-Tegretol 200mg 1 tab twice daily at 8am and 8pm.

Observation on 10/24/22 at approximately 10:20am-10:40am of Client #1, #2, and #3's medications revealed:
-Weekly blister packs with no packaging label(s) of each prescription medication including the prescriber's name, the current dispensing date,

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V 117	Continued From page 8 clear directions for administration, the name, strength, quantity and expiration date of the prescribed medication, the name, address, and phone number of the pharmacy or dispensing location, or the name of the dispensing practitioner attached to the blister packs. Various medications in the blister packs for Clients #2 and #3. Client #1's blister pack was empty. Each client's name was hand-written in black marker on the cardboard blister packaging. Interview on 10/24/22 with the Licensee/Executive Director/Qualified Professional revealed: -Received medications from the pharmacy, removed the medications from the pharmacy bottles, and then blister packed the medications himself to make it easier for staff to administer the medications; -Did not have any pharmacy labels in the facility as the pharmacy packed medication bottles with the pharmacy printed labels were thrown away after he put the medications into blister packs. This deficiency is cross references into 10A NCAC 27G .0209 Medication Requirements (V118) for a Failure to Correct Type A1 rule violation.	V 117		
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	V 118		

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V 118	Continued From page 9 clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure medications were administered on the written order of a physician affecting 3 of 3 clients (Clients #1, #2, and #3). The findings are: CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V116) Based on interview, record review, and observation, the facility failed to ensure	V 118		

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V 118	Continued From page 10 medication dispensing was restricted to registered pharmacists, physicians, or other health practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 3 of 3 clients (Client #1, #2, and #3). CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V117) Based on interview, record review, and observation, the facility failed to ensure medications were maintained with packaging labels affecting 3 of 3 clients (Clients #1, #2, and #3). Finding #1: Review on 10/24/22 of Client #1's record revealed: -Review at approximately 10:40am of the October, 2022 MAR revealed no administration of Guanfacine 4 milligrams (mg) 1 tablet (tab) at 8am on 10/24/22. Interview on 10/24/22 with Staff #1 revealed: -There was no Guanfacine available for administration to Client #1 on 10/24/22 because "it (the medication) was not authorized;" -The Licensee/Executive Director/Qualified Professional (L/ED/QP) would be able to provide further details upon his arrival to the facility. Interview on 10/25/22 with the Pharmacist revealed: -Client #1's Guanfacine was dispensed on 10/21/22 and was ready for pick-up; -Client #1's Guanfacine was not picked up until 10/24/22 at 11:22am by Staff #1. Interview on 10/24/22 and 10/25/22 with the L/ED/QP revealed:	V 118		

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-Client #1's medication was awaiting "authorization" for processing and payment and was not available for administration on 10/24/22;
-Client #1 received the last dose of Guanfacine on 10/23/22;
-Planned to contact the pharmacist this morning regarding Client #1's missed dose of Guanfacine and complete an incident report;
-Client #1's Guanfacine was picked up at the pharmacy on 10/24/22 after Division of Health Service Regulation staff requested to see the medication.

Finding #2
Review on 10/24/22 of Client #2's record revealed:
-No medications orders;
-September and October, 2022 MARs revealed administration of:
-Prazosin (urinary retention) 1mg 1 caplet (cap) at 8pm;
-Guanfacine (attention) 2mg 1 tab twice daily in the morning and evening;
-Atomoxetine HCl (attention) 25mg 1 cap daily each morning.

Interview on 10/25/22 with the L/ED/QP revealed:
-Client #2's medications were listed on the undated demographic face sheet to serve as his medication orders;
-There were no additional documents available for review regarding Client #2's medication orders.

Review on 10/25/22 of the Plan of Protection written by the Licensee/Executive Director/Qualified Professional dated 10/25/22 revealed:

"What immediate action will the facility take to

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V 118	Continued From page 12 ensure the safety of the consumers in your care? To make sure medications are dispensed, package, and labels from pharmacy. We have contacted our pharmacy to blister package medications for each client with appropriate label information. This will automate the process of packaging, labeling, and dispending medications for our staff. Describe your plans to make sure the above happens. We have contact [pharmacy manager] to ensure each client medications are blister packaged according to day and time of meds (medications) on one sheet for the month. This will ensure each client medication have label with dispensing information." Clients #1, #2, and #3 range in age from 10-18 years old. They have mental health diagnoses including Autism Spectrum Disorder, Intellectual Development Disability, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Persistent Depressive Disorder, and Schizophrenia. Medications listed on their Medication Administration Records were: Client #1 - Guanfacine; Client #2 - Atomoxetine HCL, Guanfacine, and Prazosin; Client #3 - Aripiprazole, Concerta, Nortriptyline HCL, Clonidine HCL, and Tegretol. The Licensee/Executive Director/Qualified Professional received clients' medications from the pharmacy in pharmacy packaged and labeled bottles, removed the medications from the pharmacy bottles, and packaged the medications into blister packs purchased from the internet. There were no pharmacy labels maintained on the medications. Client #1 was prescribed Guanfacine, but the medication was not	V 118		

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V 118	Continued From page 13 administered on 10/24/22 as it was not available in the facility because it had not been picked up from the pharmacy despite it having been ready for pick up for several days. The facility did not maintain medication orders for Client #2. This deficiency constitutes a Failure to Correct Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 118		
V 750	27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (3) Electrical, mechanical and water systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on interview and observation, the facility failed to ensure mechanical systems were in operating condition affecting 3 of 3 clients (Clients #1, #2, and #3). The findings are: Observation on 11/9/22 at approximately 12:30pm-1:30pm revealed: -Smoke detector beeping approximately once every one to two minutes. Interview on 11/9/22 with the Licensee/Executive	V 750		

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 _____	R 11/10/2022

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

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V 750	Continued From page 14 Director/Qualified Professional revealed: -Would change the battery in a smoke detector if he heard it beeping; -Had not noticed the smoke detector beeping; -Could not identify how long the smoke detector had been beeping as he had not heard it beeping until Division of Health Service Regulation staff brought the beeping to his attention; -Would change the battery in the smoke detector today.	V 750		
V 778	27G .0304(d)(9) Occupany Age Restrictions 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (9) Children and adolescents shall not share a bedroom with an adult. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure children or adolescents not share a bedroom with an adult affecting 2 of 3 clients (Clients #1 and #3). The findings are: Review on 10/24/22 of Client #1's record revealed: -Admitted 7/16/22; -Diagnosed with Autism Spectrum Disorder, Mild Intellectual Developmental Disability, Attention	V 778		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 778	Continued From page 15 Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD); -18 years old; -Letter dated 9/29/22 signed by the Licensee/Executive Director/Qualified Professional (L/ED/QP) sent to the Division of Health Service Regulation (DHSR) requesting a waiver for rule 10A NCAC 27G .5601(b) revealed " ...[Client #1] is in a single room and primarily sticks to himself ...Safeguards in place to keep [Client #1] isolated to a single room ...Inform staff on [Client #1's] temporary placement and the need for additional monitoring to ensure safety of other residents due to age." Review on 10/24/22 of Client #3's record revealed: -Admitted 11/8/21; -Diagnosed with DMDD, Conduct Disorder, Persistent Depressive Disorder, Autism Spectrum Disorder; -15 years old. Interview on 10/25/22 with Client #1 revealed: -Shared a bedroom with Client #3. Interview on 10/25/22 with Client #3 revealed: -Shared a bedroom with Client #1 because he "gets along" with him; -Started sharing the bedroom with Client #1 on 10/24/22 after difficulty getting along with his former roommate (Client #2). Interview on 10/25/22 with the L/ED/QP revealed: -Clients #1 and #3 shared a bedroom; -Forgot adolescents could not share a bedroom with adults; -Acknowledged the letter sent to DHSR requesting a rule waiver revealed Client #1 would have a single bedroom;	V 778		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 778	Continued From page 16 -Would ensure bedroom changes were made to ensure Client#1 was in a single room. Observation on 10/25/22 at approximately 3:00pm-3:10pm revealed: -Clients #1 and #3 returned from school and entered the double bedroom to put their belongings away.	V 778		