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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	RECEIVED DEC 15 2022 DHSR-MH Licensure Sect	

Karla Sin 10/12/2022

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL0601464		**08/30/2022**
NAME OF PROVIDER OR SUPPLIER **ROPES, INC**		STREET ADDRESS, CITY, STATE, ZIP CODE **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 105	Continued From page 2 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;	V 105	AGENCY DIRECTOR AND BOARD REVISED POLICY AND PROCEDURE MANUAL IMMEDIATELY, TO REFLECT DISCHARGE/TRANSFER POLICIES, REVIEWED AND SIGNED/DATED BY "BOARD". MEETING WAS HELD BY BOARD ON 10/03/2022 TO DISCUSS UPDATING DISCHARGE AND ADMISSION PROCEDURES. NEW POLICIES INCLUDE PROCIUDURES FOR CFT MEETINGS AND DOCUMENTING MONTHLY DISCHARGE SUMMARY. DISCHARGE SUMMARY HAS TO BE UPDATED WITH A CARE COORDINATOR FOR EACH CLIENT DURING MONTHLY CFT. EACH MONTH DISCHARGE PLAN IS UPDATED WITH CARE COORDINATOR TO ENSURE CONTIUNINTY OF CARE UPON DISCHARGE. QP IS RESPONSIBLE FOR COORDINATING MONTHLY SESSIONS WITH CFT TO UPDATE CLIENT FAMILY AND CARE COORDINATORS OF CLIENT STATUS WITHIN THE HOME FOR THE PAST 30 DAYS AND PLANS FOR THE NEXT 30 DAYAS. ED HAS ADDED FORM THAT ENSURES THAT QP HAS RECORD OF COORDINATION WITH MCO AND FAMILY. OUR NEW POLICIES ENSURE EXTRA DOCUMENTATION WILL BE SHARED WITH THE CFT COORDINATOR MONTHLY.	10/02/2022, ANNUALLY, AND ONGOING AS REVISIONS ARE WARRANTED

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	**DIRECTOR AND ALL FACILITY STAFF COMPLETED REFRESHER TRAINING COURSE IN TRANSITION/DISCHARGE PLANNING TO ASCERTAIN THAT WHEN A CLIENT IS TRANSITIONED OR DISCHARGED THAT THE FOLLOWING IS ADDRESSED AND DOCUMENTED IN CLIENT'S FILE; CLIENT'S NEEDS, SPECIFIC RECOMMENDATIONS AND ARRANGEMENT FOR FUTURE PROGRAMS AND FOLLOW-UP SERVICES.** A NEW FORM HAS BEEN ADDED TO INCLUDE FOLLOW UP FOR EACH MONTHS CFT TO BE UPDATYED BY THE QP. IN THE EVENT THAT DISCHARGE IS IMMINENT AREA AUTHORITY WILL BE CONTACTED IN WRITING BY LEAD QP AND ED WITH 60 DAY DISCHARGE NOTIFICATION. QP WILL HAVE CLINICAL LEAD UPDATE CCA ADDENDUM AND SEND TO CARE COORDINATOR. **DIRECTOR MET WITH ALL FACILITY STAFF AND DISCUSSED/TRAINED ON PROPER TRANSITIONING/DISCHARGE OF RESIDENTS AND COORDINATION OF CARE INVOLVING PARENT AND OR GUARDIAN OF RESIDENT PER POLICY.** **DIRECTOR MET WITH ALL FACILITY STAFF AND DISCUSSED/TRAINED ON PROPER TRANSITIONING/DISCHARGE OF RESIDENTS AND COORDINATION OF CARE INVOLVING PARENT AND OR GUARDIAN OF RESIDENT PER POLICY.**	**10/02/2022 AND ONGOING** **10/02/2022 AND ONGOING**

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 105	Continued From page 4 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;	V 105	DIRECTOR MET WITH ALL FACILITY STAFF AND DISCUSSED/TRAINED ON PROPER TRANSITIONING/DISCHARGE OF RESIDENTS AND COORDINATION OF CARE INVOLVING PARENT AND OR GUARDIAN OF RESIDENT PER POLICY. ED WILL ENSURE THAT TRANSFER OF CARE DOCUMENTS AND PROCEDURES HAVE BEEN DOCUMENTED AND ACKNOWLEDGED BY MCO CARE COORDINATOR AND CLIENT FAMILY. DIRECTOR HIRED AN ADMINISTRATOR WITH 5600B, RESIDENTIAL EXPERIENCE TO MAKE CERTAIN THAT ALL FACILITIES RECORDS ARE NOW PAPERLESS AND ACCESSIBLE ELECTRONICALLY, AT ALL TIMES AGENCY DIRECTOR HAS SIGNED UP WITH NC START AND MOBILE CRISIS WITH ALLIANCE MCO TO ADD TO CLIENT CRISIS PLAN AND USE PRIOR TO EMERGENCY SERVICES ARE CONTACTED. THIS ADDS ANOTHER LEVEL OF DE-ESCALATION AND MINIMIZES THE USE OF EMERGENCY SERVICES. ALL STAFF RE-TRAINED ON INCIDENTS AND CRISIS RESPONSE AND REPORTING BY ED. TEAM LEAD QP RESPONSIBLE FOR ENTERING ALL INCIDENT REPORTS WITHIN 72 HOURS.	10/02/2022 AND ONGOING 10/07/2022 AND ONGOING 09/01/2022 AND ONGOING

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	DIRECTOR MET WITH ALL FACILITY STAFF AND DISCUSSED/RE-TRAINED ON PROPER TRANSITIONING/DISCHARGE OF RESIDENTS 18 YRS OF AGE AND COORDINATION OF CARE INVOLVING PARENT AND OR GUARDIAN OF RESIDENT PER POLICY. ALSO TRAINED ON SPECIFIC RECOMMENDATIONS AND ARRANGEMENTS FOR FUTURE PROGRAMS AND FOLLOW-UP SERVICES.	09/01/2022 AND ONGOING
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		

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 109	Continued From page 6 (e) Qualified professionals as specified in 10 A 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	ED/QP HAS OVER 15 YRS DEVELOPING ISPs FOR IDD CLIENTS/CHILDREN. AND HAS TAKEN A REFRESHER COURSE IN DEVELOPING PLAN, IMPLEMENTING STRATEGIES TO ADDRESS IDD CLIENT TREATMENT, EDUCATIONAL NEEDS, CONTINUED BEHAVIORAL OUTBURST AND	09/01/2022 AND ONGOING, ANNUALLY

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFI X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

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 10 A NCAC 27G .5601 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 109	ED/QP, AND ALL FACILITY STAFF WERE /RE-TRAINED ON PROPER TRANSITIONING/DISCHARGE OF ALL RESIDENTS BEING DISCHARGED AT LEAST 60-DAYS PRIOR TO DISCHARGE INCLUDING COORDINATION OF CARE INVOLVING COUNTY, PARENT AND OR GUARDIAN OF RESIDENT PER POLICY. TRAINING CONSIST OF CONTINUITY OF CARE ALSO TRAINED ON SPECIFIC RECOMMENDATIONS AND ARRANGEMENTS FOR FUTURE PROGRAMS AND FOLLOW-UP SERVICES. ED/QP HIRED ANOTHER QPDD TO HELP SHARE RESPONSIBILITIES OF OVERSEEING FACILITY, CLIENT TREATMENT, COORDINATION OF CARE, ADMISSION, DISCHARGES, AND STAFF SUPERVISION. TOGETHER CLIENTS SCHOOLING IS OVERSEEN BY BOTH QP AND QPDD WITH ADMINISTRATOR AS 3RD BACK-UP. TEAM NOW WORKS TOGETHER TO DEVELOP TREATMENT STRATEGIES TO ADDRESS ALL CLIENT'S CONTINUING EDUCATION, HOW TO CONTROL ANGRY oUTBURST AND HOW TO UTILIZE NC START AND OTHER CRISIS RESPONSE SERVICES. QP'S PROVIDED DOCUMENTATION STATING OUR MANY DAILY ATTEMPTS AT CONTACTING THE MOTHER, SCHOOL, AND OTHER COMMUNITY RESOURCE PROVIDERS TO SEE OF OPTIONS TO GET CLIENT TO ATTEND SCHOOL. CLIENT WAS LINKED WITH HOMEBOUND PROGRAM TWICE FOR WHICH HE WAS DENIED DUE TO HIS ABILITY TO ATTEND NOT MEETING PARAMETERS OF THE PROGRAM. ROPES ALSO HAS A PLETHORA OF DOCUMENTED STRATEGIES AND ATTEMPTS FOR CLIENT TO GO TO SCHOOL. CILIENT WAS NOT ELIGIBLE TO TEST GED AS ANOTHER FAILED ALTERNATIVE. ALSO, IT'S IMPORTANT TO NOTE THAT CLIENT WAS SUSPENDED/TERMINATED FROM SCHOOL FOR MONTHS. CLIENT WAS KICKED OUT OF BOTH TRADITIONAL AND ALTERNATIVE PLACEMENT SCHOOLS, BOTH FOR WHICH HE WAS ENROLLED BY ROPES.	09/01/2022 AND ONGOING, ANNUALLY
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL0601464		08/30/2022
NAME OF PROVIDER OR SUPPLIER ROPES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 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		

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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		

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 112	Continued From page 10 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;	V 112	ED/QP HIRED ANOTHER QPDD TO HELP SHARE RESPONSIBILITIES OF OVERSEEING FACILITY, CLIENT TREATMENT PLANS TO MAKE CERTAIN THAT NEW GOALS/STRATEGIES ARE UPDATED AS NEEDED. ALL STAFF WILL REVIEW NEW INCOMING REFERRALS TOGETHER TO ASCERTAIN PROPER PLACEMENT FOR ALL POTENTIAL CLIENTS. TREATMENT TEAM MEETINGS WILL OCCUR QUARTERLY TO DISCUSS CLIENTS GOALS AND PROGRESS AND UPDATE PLANS AS NEEDED. ED/QP HIRED ANOTHER QPDD TO HELP SHARE RESPONSIBILITIES OF OVERSEEING FACILITY, CLIENT TREATMENT PLAN TO MAKE CERTAIN THAT BOTH QP AND QPDD WITH ADMINISTRATOR AS 3RD AND OTHER STAFF WORKS TOGETHER AS TEAM TO DEVELOP TREATMENT STRATEGIES TO ADDRESS ALL CLIENT'S CONTINUING EDUCATION, AND HOW TO CONTROL ANGRY OUTBURST AND HOW TO UTILIZE NC START AND OTHER APPROPRIATE CRISIS RESPONSE SERVICES AS NEEDED.	09/01/2022 AND ONGOING 09/01/2022 AND ONGOING

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFI X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

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 10 A 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL0601464		**08/30/2022**
NAME OF PROVIDER OR SUPPLIER **ROPES, INC**		STREET ADDRESS, CITY, STATE, ZIP CODE **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 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	ED/QP, QPDD AND ADMINISTRATOR ALL ARE NOW RESPONSIBLE TO MAKE CERTAIN THAT ALL FIRE DRILLS ARE IMPLEMENTED, QUARTERLY PER POLICY, ON EACH SHIFT. ALL DRILLS ARE RANDOM AND ASSIGNED TO QP ON STAFF TO PERFORM QUARTERLY AND SIGNED OFF BY STAFF ON DUTY, PER THAT SHIFT AND DOCUMENT THE DATE OF DRILL.	09/01/2022 QUARTERLY AND ONGOING
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 116		

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

NAME OF PROVIDER OR SUPPLIER

ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE

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 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		

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	ED/QP UPDATED MEDICATION DISPENSING POLICY TO REFLECT THAT FILLING MEDICATION BLISTER PACKS IS RESTRICTED TO REGISTERED PHARMACIST, PHYSICIANS, OR OTHER HEALTH CARE PRACTITIONERS AUTHORIZED BY LAW AND REGISTERED WITH THE NC BOARD OF PHARMACY. REVIEWED AND SIGNED OFF BY BOARD. ROPES COORDINATED WITH AVANT PHARMACY THE FILLING OF EACH CLIENT'S BLISTER PACK BY DAY/TIME MONTHLY. EACH MEDICATION BLISTER PACK CONTAINS APPROPRIATE LABELS FOR EACH MEDICATION. MAR FORMS PROCEDURES UPDATED SO THAT BOTH PERSONS ON STAFF INITIAL INDICATING DISPENSING OF MEDICATION. ONE SIGNATURE FOR THE PERSON THAT DISPENSES AND ONE INITIAL FOR THE PERSON THAT WITNESSES. PROCEDURES ALSO INCLUDE THAT THE DAILY COUNT IS PERFORMED TO ENSURE THAT NO DOSES HAVE BEEN MISSED OR ADMINISTERED INCORRECTLY.	09/01/2022 ONGOING ANNUALLY

			ED/QP AND ALL STAFF HAVE BEEN RE-TRAINED ON MEDICATION MANAGEMENT, MEDICATION ORDERS, AND OBSERVATIONS OF MEDICATIONS FOR EACH CLIENT IN ADDITION TO MEDICATION ADMINISTRATION TRAINING FOR EACH STAFF.	08/19/2022, 10/19/2022 AND ONGOING ANNUALLY

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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 10 A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.**	V 116	ED/QP AND ALL STAFF HAVE BEEN RE-TRAINED ON MEDICATION MANAGEMENT, DISPENSING AND POLICY UPDATED, REVIEWED, SIGNED BY BOARD. ROPES IMPLEMENT	08/19/2022, 10/19/2022 AND ONGOING ANNUALLY
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		

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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.	V 118		
	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)."		ED/QP AND ALL STAFF HAVE BEEN TRAINED ON MEDICATION ADMINISTRATION , DISPENSING AND POLICY UPDATED, REVIEWED, SIGNED BY BOARD. IN ADDITION TO MEDICATION MANAGEMENT TRAINING ROPES HAS DEVELOP A TRAINING/SYSTEM TO DEVELOP AND REVIEW MAR FORMS MONTHLY. LEAD QP WILL REVIEW MAR FORMS MONTHLY TO ENSURE EFFICACY AND SIGN INDICATING FORM HAS BEEN REVIEWED FOR CORRECT MEDICATION, DOSAGE, AND TIME FOR EACH CLIENT. ED/QP UPDATED MEDICATION DISPENSING POLICY TO REFLECT THAT MEDICATION IS RESTRICTED TO REGISTERED PHARMACIST, PHYSICIANS, OR OTHER HEALTHCARE PRACTITIONERS AUTHORIZED BY LAW AND REGISTERED WITH THE NC BOARD OF PHARMACY. REVIEWED AND SIGNED OFF BY BOARD. POLICY REVISED AND UPDATED, REVIEWED ,	08/19/2022, 10/19/2022 AND ONGOING ANNUALLY 08/19/2022, 10/19/2022 AND ONGOING ANNUALLY

			SIGNED BY BOARD	10/02/2022, ONGOING

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	ED/QP AND ALL STAFF HAVE BEEN TRAINED ON MEDICATION MANAGEMENT, DISPENSING AND POLICY UPDATED, REVIEWED, SIGNED BY BOARD. MAR REVIEWED EACH MONTH BY LEAD QP. ALL RECORDS AND MAR WILL BE ELECTRONIC AND TRACKED BY THE TEAM.	08/19/2022, 10/19/2022 AND ONGOING ANNUALLY

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	ED/QP AND ALL STAFF HAVE BEEN TRAINED ON MEDICATION MANAGEMENT, DISPENSING AND POLICY UPDATED, REVIEWED, SIGNED BY BOARD. ROPES ALSO DOES IN HOUSE TRAINING TO INCLUDE DEVELOPING MAR AND DISPENSING MEDICATION. RECORDS AND MAR WILL BE CONVERTED TO ELECTRONIC FORMAT BY 01/01/2023 AND TRACKED BY TEAM. NEW PROCEDURES INCLUDES TWO SIGNATURES THAT ENSURE EFFICACY AND COUNT OF ALL MEDICATIONS ADMINISTERED.	08/19/2022, 10/19/2022 AND ONGOING ANNUALLY

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER
ROPES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE
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 118	Continued From page 19 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	V 118	ED/QP AND ALL STAFF HAVE BEEN RE-TRAINED ON MEDICATION MANAGEMENT , DISPENSING AND POLICY UPDATED, REVIEWED, SIGNED BY BOARD. ALL RECORDS AND MAR ARE NOW ELECTRONIC AND TRACKED BY THE TEAM AGENCY NOW TRACK MAR, PHYSICIAN ORDERS, ELECTRONICALLY. EACH CLIENT MAR RECORD WILL INCLUDE SIGNED MEDICATION SERVICE ORDER TO MATCH WITH MAR FORM TO MAKE SURE THAT MAR ALIGNS WITH SIGNED DR ORDERS. THE TWO SIGNATURE SYSTEM WILL ENSURE THAT MAKE SURE MAR IS ALWAYS CURRENT AND DAILY COUNT IS PERFORMED. ALL STAFF RECEIVED ROPES IN HOUSE COURSE FROM ED/QP. BLISTER PACKS ARE FILLED BY THE PHARMACY MONTHLY.	10/02/2022 ONGOING ANNUALLY 10/02/2022, ONGOING

	Protection completed by the ED/QP dated 8/6/22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL0601464		**08/30/2022**
NAME OF PROVIDER OR SUPPLIER **ROPES, INC**		STREET ADDRESS, CITY, STATE, ZIP CODE **10721 GLENLUCE AVENUE** **CHARLOTTE, NC 28213**	