STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL032371	B. WING		R 02/13/2023
		WITI LU3237 I			02/13/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	OK ROAD W, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
V 000 INITIAL COMMENTS		V 000			
	on February 13, 20. This facility is licens category: 10A NCA Living for Adults wit				
		sed for 4 and currently has a urvey sample consisted of clients.			
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112		
	PLAN (c) The plan shall the assessment, and in legally responsible of admission for clic receive services be (d) The plan shall if (1) client outcome (achieved by provisi projected date of action (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evalua outcome achievem (6) written consent responsible party, consultar responsible party r	De developed based on the partnership with the client or person or both, within 30 days ents who are expected to eyond 30 days. Include: (s) that are anticipated to be on of the service and a chievement; (e); review of the plan at least ation with the client or legally or both; ation or assessment of			

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

TITLE (X6) DATE

PRINTED: 02/14/2023 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL032371	B. WING		F 02/1	R 3/2023
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 02/1	3/2023
		505 COO	, ,	STATE, ZII GODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 1	V 112			
	This Rule is not me Based on record refacility failed to hav Plan with written coclient's responsible by the provider stat not be obtained affereviewed (#1, #2). Review on 2/13/23 - Admission date of -Diagnoses of Esse Parkinson's Diseas Chronic Schizoaffer DeficiencyClient #1 had a legalized review on 2/13/23 - Client #1's Person consent or agreement a written statement such consent could review on 2/13/23 - Admission date of -Diagnoses of Bord Severe Acne; Pervar Recurrent Enuresis Intermittent Explosi Asthma; Attention I - Client #2 had a legalized recurrent or agreement or agreement or agreement or agreement or agreement records.	et as evidenced by: views and interview, the e an updated Person Centered onsent or agreement by the party, or a written statement ing why such consent could ecting two of three clients The findings are: of client #1's record revealed: 8/17/06. ential Hypertension; e; Chronic Kidney Disease; ctive Disorder; Vitamin D gal guardian assigned to him. Centered Plan had no written ent by the responsible party or by the provider stating why I not be obtained. of client #2's record revealed: 7/16/13. lerline Intellectual Functioning; asive Developmental Disorder; ve Disorder; Exercise Induced				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		E SURVEY PLETED	
		MHL032371	B. WING			R 13/2023
	PROVIDER OR SUPPLIER	AL SERVICES INC. 505 CO.	DDRESS, CITY, STOK ROAD M, NC 27713	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 112	such consent could Interview on 2/13/2 Professional reveal -She was responsil Centered Plans. -She was in the pro -She confirmed tha for clients #1 and #	I not be obtained. 3 with the Qualified led: ble for completing the Person locess of updating the plans. t the Person Centered Plans were not updated yet. stitutes a re-cited deficiency	V 112			
V 114	10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved to authority. (b) The plan shall be and evacuation pro posted in the facility (c) Fire and disaster shall be held at lease repeated for each so under conditions the	ncy Plans and Supplies 207 EMERGENCY PLANS an for each facility and plan shall be developed and by the appropriate local be made available to all staff cedures and routes shall be y. br drills in a 24-hour facility est quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies	V 114			
	failed to ensure tha	view and interviews the facility t and fire drills and a disaster d at least quarterly on each	,			

Division of Health Service Regulation STATE FORM

6899 7IC111 If continuation sheet 3 of 11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					 	۲ ا
		MHL032371	B. WING			3/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOI	C ROAD , NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 114	Continued From pa	ige 3	V 114			
	Review on 2/13/23 book revealed: -There were no fire for the 1st quarter of the 1st quarter of the 2nd shift for the 2nd shift for the 2nd shift for the 3rd quarter of the 3rd quarter of the 3rd quarter of the 2nd shift for the 4th of the 2nd shift for the 4th of the 2nd shift for the 1st quarter of the 3rd quarter	of the facility's fire drills log drills conducted for 2nd shift of 2022. drills conducted for 1st and d quarter of 2022. drills conducted for 2nd shift of 2022. drills conducted for 1st and quarter of 2022. drills conducted for 1st and quarter of 2022. of the facility's disaster drills aster drills conducted for 2nd arter of 2022. aster drills conducted for 1st e 2nd quarter of 2022. aster drills conducted for 2nd arter of 2022. aster drills conducted for 1st e 2nd quarter of 2022. aster drills conducted for 1st e 4th quarter of 2022. 3 with the Qualified led: nder two shifts. n 8:00 AM to 5:00 PM. Second PM to 8:00 AM. fused on how often the fire had to be conducted. state's rule regarding fire and house staff. ff failed to conduct drills under ulate fire emergencies under quarter. ustitutes a re-cited deficiency				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					 F	3
		MHL032371	B. WING		02/1	3/2023
NAME OF PRO\	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S CAS	STLE RESIDENTIA	AL SERVICES INC 505 COOP	ROAD , NC 27713			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 118 Co	Continued From page 4		V 118			
V 118 27	G .0209 (C) Med	ication Requirements	V 118			
RE (c) (1) on ord (2) clie clie (3) ad un ph pri (4) all cu rec M/A (B) (C) (D) (E) dru (5) che file with	EQUIREMENTS) Medication admi) Prescription or rely be administered or of a person are ugs.) Medications shatents only when are ent's physician.) Medications, incoministered only be alicensed persons armacist or other evileged to prepare (vileged to prepare) A Medication Addrugs administer rrent. Medication Addrugs administer rrent. Medications for a corded immediate (AR is to include the corded immediate (AR) instructions for a corded and time the corded immediate (AR) instructions for a corded and time the corded an	non-prescription drugs shall and to a client on the written authorized by law to prescribe all be self-administered by authorized in writing by the sluding injections, shall be by licensed persons, or by a trained by a registered nurse, are legally qualified person and the and administer medications. Iministration Record (MAR) of the documents of the documents of the sadministered shall be all after administration. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			₹
		MHL032371		B. WING			13/2023
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	505 COOL	ROAD NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	interview the facility orders for administration of three audited clie Ensure the medical (MAR) was current (#1). The findings a Review on 2/13/23 -Admission date of -Diagnoses of Esse Parkinson's Diseas Chronic Schizoaffer Deficiency. Review on 2/13/23 orders dated 6/22/2 -Losartan 25 milligr -Vitamin D3 2000 it -Carbidopa/Levodo one tablet three tim -Divalproex Sodium a dayFluvoxamine Male bedtimeRisperidone 4 mg, -Trazodone 50 mg, -There were no ord eye Solution, place -There were no ord 50 mg, take four tal Observation on 2/1 medications revealed -All medications were recommended.	eview, observations of failed to: A) Have pered medications aftents (#1 and #3); and tion administration refor one of three audiare of Client #1's record 8/17/06. ential Hypertension; e; Chronic Kidney Disorder; Vitanto of client #1's physical revealed: am (mg,) one tablet at J., one tablet a day. pa 10-100 milligrammes a day. In 500 mg, one tablet at bedtimone to two tablets at ers for Latanoprost one drop to both eyers for Fluvoxamine blets at bedtime. 3/23 at 12:20 pm of ed: ere available. of client #1's Medical ord (MAR) for the medical at the medical cord (MAR) for the medical and many conditions are sailable.	ohysician fecting two d B) ecord lited clients d revealed: disease; nin D ian's a day. s (mg,) t two times mg at ne. diseate Client #1's ation onths of	V 118			
		ough February 13, 2 the following dates:					

Division of Health Service Regulation

STATE FORM 6899 7IC111 If continuation sheet 6 of 11

	Of Fleatin Service IN		(A(O) NALII TIBI	F CONCERNATION	1000 BATE	OLIDVEN (
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
, , , , , , , , , , , , , , , , , , , ,	5. 55111E511611	DERTH 10, CLOW NOWDER.	A. BUILDING:			
					F	₹
		MHL032371	B. WING		02/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		505 COO				
ROSE'S	ROSE'S CASTLE RESIDENTIAL SERVICES INC					
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IGIENOT)		
V 118	Continued From pa	ge 6	V 118			
	January 2023:					
	-Losartan 25 mg, 1	/16-1/31 @ 8 am.				
		ı, 1/15-1/31 @ 8 am.				
		pa 10-100 mg, 1/15-1/31 @ 8				
	am, 2 pm, 8 pm.	-				
	-	n 500 mg, 1/15-1/31 @8 am, 8				
	pm.	4/40/4/04 0 0				
		ate 50 mg, 1/16/1/31@ 8 pm. % eye Solution, 1/16-1/31 @ 8				
	pm.	% eye 30idil011, 1/10-1/31 @ 6				
	-Risperidone 4 mg,	1/15-1/31 @ 8 pm.				
		1/15-1/31 @ 8 pm.				
	J.					
		of client #3's record revealed:				
	-Admission date of					
		ertension; Diabetes Mellitus				
	Type II; Schizoaffed					
		Reflux; Hyperlipidemia; Right Dyslipidemia; Renal Mass.				
	The Ostobartimus, i	bysiipideima, rtenai ivides.				
	Review on 2/13/23	of client #3's physician's				
	orders revealed:	, ,				
		ers for Tamsulosin 0.4 mg,				
	one capsule a day.					
	Observation on 2/1	2/22 at 12:25 pm of alignt #2!a				
	medications reveal	3/23 at 12:35 pm of client #3's				
	-Tamsulosin 0.4 mg					
		,				
	Review on 2/13/23	of client #3's MAR for the				
		er 2022 through February 13,				
	2023 revealed:					
		inistered Tamsulosin 0.4 mg				
	2023.	er 2022 through February 13,				
	2020.					
	Interview on 8/23/2	2 with the Qualified				
	Professional reveal					
		e that some of the client's				
	medication orders \	were not on file.				

Division of Health Service Regulation

STATE FORM 6899 7IC111 If continuation sheet 7 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		F	
		MHL032371	B. WING		1	3/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COOP	(ROAD NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	-Client #1 saw a different scripts for the eye of from their office to a sure they complete. She was aware the #1's MARShe had written a on his MAR, but fai staffStaff reported they why the blanks wer. She confirmed the January MARShe confirmed the currentShe acknowledged copy of the scripts in	ferent eye doctor and his drops had been sent directly the pharmacist. Were responsible for making d the MAR accordingly. At there were blanks on client post-it note and had placed it led to review the MAR with the did not know or remember e on client #1's January MAR. The were blanks on client #1's facility failed to keep the MAR d the facility failed to have a for all the clients. Stitutes a re-cited deficiency	V 118			
V 121	10A NCAC 27G .02 REQUIREMENTS (f) Medication revie (1) If the client rece governing body or of for obtaining a revie regimen at least ev shall be to be perfo physician. The on-s the client's physicia the review when me (2) The findings of	w: bives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or site manager shall assure that in is informed of the results of edical intervention is indicated, the drug regimen review shall client record along with	V 121			

Division of Health Service Regulation STATE FORM

6899 7IC111 If continuation sheet 8 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		F	,
		MHL032371	B. WING			3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC 505 COO DURHAM	K ROAD I, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 121	Continued From pa	age 8	V 121			
	Based on record refacility failed to obta months for three of who received psychare: Review on 2/13/23 -Admission date of -Diagnoses of Esse Parkinson's Diseas Chronic Schizoaffe DeficiencyClient #1 had a ps completed on 10/2There was no evic psychotropic drug in Review on 2/13/23 orders dated 6/22/2Carbidopa/Levodo one tablet three times.	ential Hypertension; se; Chronic Kidney Disease; ctive Disorder; Vitamin D ychotropic drug review 2/21. dence of a current six month review for client #1. of client #1's physician's 22 revealed: opa 10-100 milligrams (mg,)				
	a day. -Fluvoxamine Male	eate 50 mg, take 50 mg at				
		one tablet at bedtime. one to two tablets at bedtime.				
	Administration Rec December 2022 th revealed:	of client #1's Medication cord (MAR) for the months of rough February 13, 2023				
		December 2022 through				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
							R
		MHL032371		B. WING		02/	13/2023
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ROSE'S	CASTLE RESIDENTIA	AL SERVICES INC	505 COOL	ROAD , NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 121	Continued From pa	ige 9		V 121			
	-Admission date of -Diagnoses of Bord Severe Acne; Perva Recurrent Enuresis Intermittent Explosi Asthma; Attention I -Client #2 had a psycompleted on 10/22 -There was no evid psychotropic drug review on 2/13/23 orders dated 2/6/23 -Lorazepam 0.5 mg two tablets at noon tablet at bedtimeAmantadine 100 mmorning, 1 capsule the evening with me-Lithium Carbonate morning and 2 caps	lerline Intellectual Furasive Developmentals; Schizoaffective Disive Disorder; Exercis Deficit Disorder. Sychotropic drug review for client #2. ence of a current sizeview for client #2. of client #2's physic of client #2's physic of a revealed: g, one tablet in the mand one capsule in the at noon and one capsule in the at noon and one capsules nighty. three tablets in every size of the size of t	unctioning; all Disorder; sorder: se Induced ew x month ian's norning, and 1 ne apsule in in the				
		n 250 mg, three table	ets at				
	months of Decemb 2023 revealed: -Client #2 was adm	of client #2's MAR for er 2022 through Feb inistered the above December 2022 thro	oruary 13,				
	-Admission date of -Diagnoses of Hype Type II; Schizoaffed	ertension; Diabetes	Mellitus				

6899

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL032371	B. WING		1	R 13/2023
	PROVIDER OR SUPPLIER CASTLE RESIDENTIA	AL SERVICES INC 505 COO		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 121	Hip Osteoarthritis; I -Client #3 had a psy completed on 10/22 -There was no evid psychotropic drug r Review on 2/13/23 orders dated 2/6/23 -Bupropion 150 mg -Divalproex Sodium bedtimeHydroxyzine 25 mg -Trazodone 50 mg, -Lorazepam 1 mg, needed. Review on 2/13/23 months of December 2023 revealed: -Client #3 was adm medications from D February 13, 2023. Interview on 2/13/23 Professional reveal -She thought the client properties of the completed since 20 -She would have the client's psychotropic -She confirmed the review for the client	Dyslipidemia; Renal Mass. ychotropic drug review 2/21. ence of a current six month eview for client #3. of client #3's physician's revealed: , one tablet daily. a 250 mg, three tablets at g, four tablets at bedtime. one tablet at bedtime. one tablet twice a day as of client #3's MAR for the er 2022 through February 13, inistered the above becember 2022 through a with the Qualified ed: ent's medication reviews had er that the medication reviews edications had not been 21. e pharmacist review the comedications. six months psychotropic drug is were not completed.	V 121			