Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMI LETED
		MHL0411217	B. WING		05/17/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ROYAL H	OUSE OF CARE		ERPOINT DRIV SUMMIT, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on May 17, 2024. Details facility is license category: 10A NCAC Living for Adults with This facility is license census of 3. The surv	d for the following service 27G .5600C Supervised Developmental Disability. d for 3 and has a current yey sample consisted of			
V 114	audits of 3 current clients.  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.		V 114		
	failed to ensure that f	as evidenced by: ew and interview, the facility ire and disaster drills were v and repeated for each shift.			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		MHL0411217	B. WING		05/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
ROYAL HO	OUSE OF CARE		TERPOINT DRIV			
			S SUMMIT, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	<b>1</b>	V 114			
	STREET ADDRE STOP WATE BROWNS SI  A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  14 Continued From page 1  Review on 5/17/24 of the facility's fire and disaster drill log between 5/31/23 to 3/15/24 revealed:  -No documentation of a 1st shift fire drill and no documentation of a 1st and 3rd shift disaster drill for the 1st quarter (January, February, March)No documentation of a 2nd and 3rd shift fire drill and no documentation of a 1st and 3rd shift fire drill and no documentation of a 1st and 3rd shift disaster drill for 2nd quarter (April, May, June)No documentation of a 1st and 3rd shift fire drill and no documentation of a 1st and 3rd shift disaster drill for 3rd quarter (July, August, September)No documentation of a 2nd and 3rd shift fire drill and no documentation of a 1st and 3rd shift disaster drill for 4th quarter (October, November, December).  Interview on 5/17/24 with Client #1 revealed: -Fire drills and hurricane drills were practiced at the facilityHe did not know when the last drill was practiced or what drill was practicedThe meeting place for fire drills was outside at the mailbox and they (Clients #1, #2 and #3) went into the bathroom for hurricane drills.  Attempted interview on 5/17/24 with Client #2 revealed: -He was non-verbal and unable to answer questions about fire and disaster drills at the facility.  Interview on 5/17/24 with Client #3 revealed: -He was non-verbal and unable to answer questions about fire and disaster drills at the facility.  Interview on 5/17/24 with Client #3 revealed: -He had not practiced fire or tornado drills since his admission.					
		with Staff #1 revealed: rills by making a sound to				

Division of Health Service Regulation

alert Clients #1, #2 and #3 that she was doing a

STATE FORM 9CCF11 If continuation sheet 2 of 10

1 '		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL0411217	B. WING		05/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
		5709 WAT	ERPOINT DRIV	· /F		
ROYAL H	OUSE OF CARE		SUMMIT, NC 2			
	OLIMANA DV OT		1		NI	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULI  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	D BE COMPLETE	
V 114	Continued From page	<u> </u>	V 114			
		_				
	fire drill.					
		t fire and disaster drills she				
	conducted was about	2 months ago.				
	Intonvious on 5/17/24	with Staff #2 revealed:				
		fire drill "a couple of times"				
	with the last one in M	•				
	-He had not ran any o					
	-110 flad flot fall dify c	alouster dring.				
	Interviews on 5/16/24	and 5/17/24 with Staff #3				
	revealed:					
	-The facility had 3 shi	fts-1st shift was from around				
	_	o around 3:00 pm, 2nd shift				
	was from around 3:00	) pm or 4:00 pm to about				
	11:00 pm and 3rd shi	ft ran from 11:00 pm to the				
	next morning.					
		re running the fire and				
		re keeping up running the				
	drills like they are sup	oposed to.				
	This deficiency consti	itutes a re-cited deficiency				
	and must be correcte	d within 30 days.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	27 © .0200 (O) Modio	auon requiremente				
	10A NCAC 27G .0209	9 MEDICATION				
	REQUIREMENTS	:-44:				
	(c) Medication admini					
		n-prescription drugs shall to a client on the written				
		horized by law to prescribe				
	drugs.	To Proceed				
		be self-administered by				
		horized in writing by the				
	client's physician.	<u> </u>				
		ding injections, shall be				
	. ,	licensed persons, or by				
		rained by a registered nurse,				
	pharmacist or other le	egally qualified person and				

Division of Health Service Regulation

STATE FORM 9CCF11 If continuation sheet 3 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (2)		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED	
		MHL0411217	B. WING		05/	17/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
ROYAL H	OUSE OF CARE	5709 WAT	TERPOINT DRIV	E			
KOTALTI	OOSE OF CARE	BROWNS	SUMMIT, NC 2	7214		_	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 118	(4) A Medication Admall drugs administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug.  (5) Client requests for checks shall be recordinated.	and administer medications.  inistration Record (MAR) of d to each client must be kept administered shall be v after administration. The following:  nd quantity of the drug;	V 118				
	drugs were administed person authorized to to ensure the MAR for current. The findings  Reviews on 5/16/24 arecord revealed: -An admission date of plagnoses of Autism Intermittent Explosive Developmental Disable Enuresis and Hypothig-1/3/24 physician ordinates to the person authorized to the person authorized	ew, observation and failed to ensure prescription ared on the written order of a prescribe drugs, and failed reach client was kept are:  and 5/17/24 of Client #1's  f 11/9/15.  Spectrum Disorder, e Disorder, Mild Intellectual dility (IDD), Pedophilia, yroidism.					

Division of Health Service Regulation

STATE FORM 9CCF11 If continuation sheet 4 of 10

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY IPLETED
		MHL0411217	B. WING		0:	5/17/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
ROYAL HO	OUSE OF CARE		TERPOINT DRIVE S SUMMIT, NC 27			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 118	effects of other medic -Haloperidol 2 mg ( dailyDivalproex Sodium 500 mg (sleep), 3 tab -Vitamin D2 1.25 (5 deficiency), 1 capsule -Desmopressin Ace at bedtimeNo physician order for every morning.  Reviews on 5/16/24 arecord revealed: -An admission date o -Diagnoses of Autism Incontinence5/17/24 physician or -Vitamin D2 (Vitamin (cap) once weekly.  Reviews on 5/16/24 arecord revealed: -An admission date o -Diagnoses of Mild ID Attention-Deficit Hype Oppositional Defiant Reactive Attachment -4/16/24 physician or -Olanzapine 10 mg with 20 mg for 30 mg -Olanzapine 20 mg 30 mg total dose.	twice daily. ate 1 mg (reduce side cations) 1 tab twice daily. behaviors), 2 tabs once  a Extended Release (ER) s at bedtime. 0,000 Units) (Vitamin Decap) once a week. cate 0.2 mg (Enuresis) 1 tab  or Haloperidol 5 mg, 1 tab  and 5/17/24 of Client #2's  f 1/24/23. , Severe IDD, and Urine  der for: n D deficiency), 1 capsule  and 5/17/24 of Client #3's  f 4/5/24. DD, Schizoaffective Disorder, caractivity Disorder (ADHD), Disorder, and history of Disorder. ders for: (Schizoaffective), 1 tab daily	V 118			

Division of Health Service Regulation

daily.

-Gabapentin 300 mg (anti-seizure), 1 cap once

STATE FORM 9CCF11 If continuation sheet 5 of 10

Division o	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			-			
			5 14/11/0			
		MHL0411217	B. WING	<del></del>	05/1	7/2024
NAME OF D	OVIDED OD CUDDUED	CTDEET A	DDECC CITY CTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
ROYAL HO	OUSE OF CARE	5709 WA	TERPOINT DRIV	Έ		
KOIALIK	JOOL OF GAILE	BROWNS	S SUMMIT, NC 2	27214		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 118	Continued From nego	- F	V 118			
V 110	Continued From page	÷ 5	V 110			
	Reviews on 5/16/24 a	and 5/17/24 of Client #1's				
	MARs from March 20					
	revealed:	_ : a.g. :a, _ = - :				
		e was staff initialed as				
	•	aily from 3/1/24- 3/31/24 and				
		at the 8 am and 8 pm dose				
	times.					
	-Haloperidol 5 mg wa					
		1/24- 3/31/24 at the 8 am				
	dose time.					
		no explanation whether the				
	medication was admi	nistered for:				
	-Benztropine Mesyl	ate on 3/8/24, 3/22/24,				
	3/28/24 at 8 pm dose	time.				
	-Haloperidol 2 mg c	on 3/20/24 at 8 am dose				
	time.					
	-Divalproex Sodium	on 3/8/24 and 3/18/24 at 8				
	pm dose time.					
	•	the week from 3/9/24				
	through 3/16/24.	and Wook Helli 6/6/2 !				
	J	etate on 5/14/25 at 8 pm				
	dose time.	tate on 3/14/23 at 6 pm				
		was provided for review.				
	-110 April 2024 MAIX V	was provided for review.				
	Pavious on 5/16/24 s	and 5/17/24 of Client #2's				
		and 5/17/24 of Client #2's				
	MARs from March 20	24 through May 2024				
	revealed:					
		aff initials and no explanation				
		on was administered on				
	3/15/24, 3/22/24, 3/29	9/24, 4/19/24 and 4/26/24 at				
	8 pm.					
	Reviews on 5/16/24	and 5/17/24 of Client #3's				
	MARs from March 20	24 through May 2024				
	revealed:					
	- No April 2024 MAR	was provided for review.				
		•				
	Observation on 5/16/2	24 at 11:30 am of Client #1's				

Division of Health Service Regulation

medications revealed:

-No Quetiapine Fumarate medication was

STATE FORM 9CCF11 If continuation sheet 6 of 10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411217	B. WING		05/17/2024	
					05/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	•		
ROYAL H	OUSE OF CARE		TERPOINT DRIV S SUMMIT, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 6	V 118			
	present at the facility.					
	-He took medicine for sleepStaff gave him his m -He had no problems -His medicine was "al Attempted interview v -He was non-verbal a his medications.  Interview on 5/17/24 v -He took medicine in nightStaff gave him his m problems taking his n Interview on 5/17/24 v used by the facility re	taking his medicine. Iways here I think."  with Client #2 revealed: and had no responses about  with Client #3 revealed: the morning and medicine at  edicines and had no nedicine.  with the local pharmacy				
	on 12/18/24, and Clie refills on this medicat	nt #1's physician denied ion on 4/18/24 because the				
	medication was "no lo	onger appropriate."				
	-He administered med and #3. -There was no differe medications listed on medications at the fac -He recorded each cli	each client MAR and the cility.				

Division of Health Service Regulation

(clients) had gone to sleep.

STATE FORM 9CCF11 If continuation sheet 7 of 10

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED	
		MHL0411217	B. WING		05/1	7/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
			ERPOINT DRIV				
ROYAL HO	DUSE OF CARE		SUMMIT, NC 2				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE	
V 118	Continued From page	e 7	V 118				
V 736	Interview on 5/17/24 with Staff #3 revealed: -He managed the group home which included oversight of the client medications and review of the clients' MARsThe local pharmacy provided the monthly clients' MARs when the clients' medications were deliveredHe did not know the reasons Clients #1, #2 and #3 had medications on their MARs without staff having initialed or provided as explanation regarding the blanks on each of the MARsHe believed staff gave clients their prescribed medicationsThe doctor's order for Client #1's Haloperidol 5 mg should be at the contracted company's office, which maintained client records on Clients #1, #2 and #3The clients' March 2024 and April 2024 MARs were at the company's officeHis staff needed medication re-training.		V 736				
		EMENTS					
		as evidenced by: n and interview, the facility n an attractive manner. The					
	12:50 pm-1:30 pm re	cility on 5/16/24 between vealed: -plastered and unpainted					

Division of Health Service Regulation

STATE FORM 9CCF11 If continuation sheet 8 of 10

Division o	of Health Service Regu	lation					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL0411217	B. WING		05/17/2024		
NAME OF D	ROVIDER OR SUPPLIER	ethert A	DDDESS CITY STA	TE ZID CODE			
NAIVIE OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA				
ROYAL HO	OUSE OF CARE		TERPOINT DRIV				
		BROWN	S SUMMIT, NC 2	2/21 <b>4</b> 			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD			
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR			
				DEFICIENCY)			
V 736	Continued From page	e 8	V 736				
	areas on the wall of the	ne stairs leading to Clients					
	#1, #2 and #3's bedro	ooms. The sizes of the					
	plastered areas range	ed from 1"x 1" to a 5" x 5"					
	area.						
		had a white-plastered and					
	•	s wall at the head of his bed					
	with at least five scuff						
	•	Il beside his bed with at least brown and black marks.					
		door had a hole at the					
		at was approximately 3"x 3"					
	in size.						
	-Client #1's room had	various brown and white					
	stains on his gray-col						
		had pin-sized holes in his					
		r on his wall and about 9					
		n door where paint had					
	peeled away.	in the hallway had holes in					
	the wall near the show						
	Interview on 5/17/24	with Clients #1 revealed:					
	-He did not know of a	ny repairs needed at the					
	facility.						
		with Client #3 revealed:					
	fixed.	ken and was waiting to be					
		g his clothes at another					
	place.	g mis diotrics at another					
	p.s.55.						
	Interview on 5/16/24	with Staff #1 revealed:					
	-She was not aware of any repairs needed at the						
	facility.						
		:11 01 15 110					
		with Staff #2 revealed:					
	-Client #1 had gotten kicked the hole in his	mad the previous week and					
		naintenance staff the day					
	-olali #5 laikeu Willi I	namichanice stall the day	- 1				

Division of Health Service Regulation

before yesterday (5/16/24) to replace the door.

STATE FORM 9CCF11 If continuation sheet 9 of 10

Division of Health Service Regulation

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D WING			
		MHL0411217	B. WING		05/1	7/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL H	OUSE OF CARE		RPOINT DRIV			
	QUILLEN/ QT		SUMMIT, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page	9	V 736			
	revealed: -The holes in the hall having moved furnitur repaintedThe places in Client: holes Client #1 put in -The rooms of Clients be repainted. He had previous day about pa-He was having maint Client #1's bedroom c-Client #1 was inconti his floor and mattress -The places in Client: removed from his wal -There was a towel he clients' bathroom that bathroom wall. He wo-He had a warranty of working, a repairman the dryer and it will be or another dryer to re	#1's bedroom came from the wall. #1, #2 and #3 needed to contacted a painter on the ainting the walls. tenance staff to replace door. nent (urine) and urinated on #2's bedroom came items I and bedroom door. blder he had removed in the caused the holes in the build have this wall repaired. In the dryer that was not came out last week about #7-10 days to get it repaired place the one not working. In the clients' clothes at his				

Division of Health Service Regulation

STATE FORM 9CCF11 If continuation sheet 10 of 10