| AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER: | | ` ′ | LE CONSTRUCTION : | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|----------------------|--|---------|-------------------------|
| | | | B. WING | | R | |
| | MHL032371 | | | | 01/14/2 | 025 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | |
| BOSE'S | CASTI E DESIDENTIA | N SERVICES INC 505 CC | OK ROAD | | | |
| RUSE S | CASTLE RESIDENTIA | DURHA | M, NC 27713 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 C | (X5) OMPLETE DATE |
| V 000 | INITIAL COMMENT | rs | V 000 | | | |
| | on January 14, 202 This facility is licens | w up survey was completed 5. Deficiencies were cited. sed for the following service | | | | |
| | Living for Adults wit | C 27G 5600A Supervised th Mental Illness. | | | | |
| | | sed for 4 and has a current urvey sample consisted of clients. | | | | |
| V 113 | 27G .0206 Client R | ecords | V 113 | | | |
| | (a) A client record sindividual admitted contain, but need n (1) an identification (A) name (last, first (B) client record nur (C) date of birth; (D) race, gender an (E) admission date; (F) discharge date; (2) documentation of developmental disardiagnosis coded ac (3) documentation of assessment; (4) treatment/habilit (5) emergency infor shall include the nanumber of the personal sudden illness or a condition and telephone numphysician; (6) a signed statem | face sheet which includes: , middle, maiden); mber; Ind marital status; of mental illness, abilities or substance abuse according to DSM IV; of the screening and tation or service plan; rmation for each client which ame, address and telephone on to be contacted in case of accident and the name, addresser of the client's preferred | SS | | | |
| | responsible person | granting permission to seek om a hospital or physician; | | | | |

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

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | SLIB//EV | |
|---|---|---|----------------|--|----------|--------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | | (X3) DATE SURVEY COMPLETED | | |
| | | | 7 50.25 10. | | R | |
| | | MHL032371 | B. WING | | 1 | 4/2025 |
| NAME OF | | | | 27ATE 7/D 00DE | 1 0.71 | 1/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| ROSE'S | CASTLE RESIDENTIA | AL SERVICES INC DURHAM | NC 27713 | | | |
| (VA) ID | CLIMMA DV CTA | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | | (VE) |
| (X4) ID PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOUL | .D BE | (X5) COMPLETE DATE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| V 113 | Continued From no | go 1 | V 113 | | | |
| V 113 | • | | VIII | | | |
| | | of services provided; | | | | |
| | (9) if applicable: | of progress toward outcomes; | | | | |
| | | of physical disorders | | | | |
| | | to International Classification | | | | |
| | of Diseases (ICD-9 | | | | | |
| | (B) medication orders (C) orders and copi | | | | | |
| | (D) documentation | of medication and | | | | |
| | administration error | s and adverse drug reactions. | | | | |
| | . , | all ensure that information | | | | |
| | | related conditions is disclosed with the communicable | | | | |
| | | ecified in G.S. 130A-143. | | | | |
| | • | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | This Rule is not me | at an avidanced by | | | | |
| | | view and interview, the facility | | | | |
| | | ned consent to seek | | | | |
| | emergency treatme | nt from a hospital or physician | | | | |
| | for 1 of 3 audited cl | ients (#3). The findings are: | | | | |
| | Review on 1/14/25 | of client #3's record revealed: | | | | |
| | -Admission date of | | | | | |
| | | zophrenia; Hypertension; | | | | |
| | | Apnea); Tobacco Use; | | | | |
| | Dyslipidemia; Obes -Client #3 had a leg | | | | | |
| | | ed consent from client #3's | | | | |
| | | granted permission to seek | | | | |
| | emergency care. | | | | | |
| | Interview on 1/14/2 | 5 with the Qualified | | | | |
| | Professional reveal | | | | | |
| | | client #3's legal guardian sign | | | | |

Division of Health Service Regulation

STATE FORM STATE FORM JEGS 11 Jegs 2 Jegs 2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---------------------|---|--------------------------------|--------------------------|
| | MHL032371 | | B. WING | | | R 1 4/2025 | |
| NAME OF | | WIIILU32371 | 0.7.0.5.7.4.0. | | DIATE ZID CODE | 01/ | 14/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | 505 COOL | | STATE, ZIP CODE | | |
| ROSE'S | CASTLE RESIDENTIA | AL SERVICES INC | | NC 27713 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED B CONTROL METERS ME | / FULL | ID PREFIX TAG | PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 113 | Continued From pa | ge 2 | | V 113 | | | |
| | the consent to seek emergency careShe acknowledged client #3 did not have a signed consent to seek emergency treatment. | | | | | | |
| V 114 | 27G .0207 Emerge | ncy Plans and Supp | lies | V 114 | | | |
| | 10A NCAC 27G .02 AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emerg request. The plans procedures and rou (b) The plans shall and evacuation pro posted in the facility. (c) Fire and disaste shall be held at leas repeated for each s Drills shall be condi simulate the facility emergencies. (d) Each facility sha accessible for use. | and shall make a cole gency services agents shall include evacuates. be made available to cedures and routes or drills in a 24-hour st quarterly and shall shift. ucted under conditions response to fire | fire plan opy of ncies upon ation o all staff shall be facility I be | | | | |
| | This Rule is not me Based on record re facility failed to ensi conducted quarterly findings are: | view and interviews ure fire and disaster | drills were | | | | |
| | Review on 1/14/25 | of the facility's fire d | rills log | | | | |

Division of Health Service Regulation STATE FORM

⁶⁸⁹⁹ ZE2G11 If continuation sheet 3 of 9

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---|---------------------|---|--------------------------------|--------------------------|
| | | MHL032371 | | B. WING | | l l | R 14/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ROSE'S | CASTLE RESIDENTIA | AL SERVICES INC | 505 COOL | _ | | | |
| (VA) ID | SHIMMA DV STA | TEMENT OF DEFICIENCIE | | , NC 27713 | DBOVIDED'S DI AN OE C | CORRECTION | (VF) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | / FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 114 | Continued From pa | ge 3 | | V 114 | | | |
| | -There were no fire quarter (April, May, -There were no fire the 3rd quarter (Jul 2024There were no fire the 4th quarter (Oc of 2024. Review on 1/14/25 log from 1/14/24 the There were no disc 2nd quarter (April, I There were no disc 3rd quarter (July, A There were no disc | drills for 1st and 2ry, August, September, August, September of the facility's disaster drills for 2nd sly May, June) of 2024. aster drills for 2nd sly ugust, September) caster drills for 1st an October, November | or the 2nd and shift for er) of d shift for eccember) ter drills led: nift for the nift for the of 2024. d 2nd shift | | | | |
| | #4 revealed: -Facility conducted -Facility conducted -Clients #1, #2, #3 even of a fire drill, t front of the facility a mailboxClients #1, #2, #3 event of a tornado, facility's hallway that close all the bedrood Interview on 1/14/2 -She conducted fire facility with the clier -She thought all reconducted. | disaster drills. and #4 verbalized th hey would all go out and meet by the facil and #4 verbalized th they would gather a at leads to their bedroms doors and croud 5 with staff #4 revea and disaster drills a ths. quired drills had been | at in the to the ity's at in the the coms, ch down. | | | | |
| | Interview on 1/14/2 | 5 with the Qualified | | | | | |

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Division of Health Service Regulation STATE FORM

ZE2G11 If continuation sheet 4 of 9

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | ` ′ | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
|--------------------------|---|---|---|----------------------|---|-------------------|--------------------------|
| | | | | A. BOILDING. | | , | R |
| | | MHL032371 | | B. WING | | | 14/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ROSE'S | CASTLE RESIDENTIA | AL SERVICES INC | 505 COOL | K ROAD , NC 27713 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 114 | Professional revea -Facility operated u -First shift was fron -Second shift was for -She knew this defi -A schedule calend time this deficiency follow itShe confirmed the and disaster drills f shift. | led: nder 2 shifts. n 8 am to 5 pm. from 5 pm to 8 am. ciency had been cited ar had been created from soited, but staff far facility failed to compor each quarter and for | the last ailed to blete fire or each | V 114 | | | |
| V 121 | 10A NCAC 27G .02 REQUIREMENTS (f) Medication revie (1) If the client receive governing body or for obtaining a revier regimen at least evishall be to be perforphysician. The onsthe client's physiciathe review when m (2) The findings of | ew: sives psychotropic dru pperator shall be resp ew of each client's dru ery six months. The resp rmed by a pharmacis site manager shall ass in is informed of the re edical intervention is it the drug regimen revi client record along wi | igs, the consible ig eview to or sure that esults of indicated. | V 121 | | | |
| | | et as evidenced by: eviews and interviews ain drug regimen revie | | | | | |

Division of Health Service Regulation STATE FORM

ZE2G11 If continuation sheet 5 of 9

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---|---------------------|--|-----------------------------------|--------------------------|
| | | MHL032371 | | B. WING | | | R 14/2025 |
| | PROVIDER OR SUPPLIER | AL SERVICES INC | 505 COO | , , | TATE, ZIP CODE | | |
| (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 AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 121 | received psychotron Review on 1/14/25 -Admission date of -Diagnoses of Bord Severe Acne; Perva Recurrent Enuresis Intermittent Explosi Asthma; Attention I -Physician's orders -Lithium Carbo one capsule twice of one in the eveningPhysician's orders -Lorazepam 0.5 the morning and tw -Clozapine 100 the evening with me -Clozapine 100 at bedtimeDivalproex Soft tablets daily at bedf -The last time a six was conducted was -There was no evid psychotropic drug r Review on 1/14/25 Administration Rec November 1, 2024 revealed: -Client #1 was adm medications from N January 14, 2025. | 3 clients (#1, #2 and pic drugs. The finding of client #1's record 6/14/13. Iterline Intellectual Fusive Developmentally; Schizoaffective Disve Disorder; Exercis Deficit Disorder. dated 2/29/24: nate 300 milligrams daily (one in the mor) dated 3/15/24: 5 mg- Take one table to tablets daily in the mg- Take three tables. mg- Take three tables. mg- Take three tables. mg- Take three tables img- Take three tables of a current size s/7/24. ence of a current size view for client #1. of client #1's Medica ord (MAR) for the mathrough January 14 inistered the above lovember 1, 2024 the of www.webmd.com | revealed: unctioning; al Disorder; se Induced (mg)- take rning and et daily in e evening. lets daily in lets daily three c review x month ation conths of , 2025 | V 121 | | | |
| | | disorder (bipolar disc | order). | | | | |

Division of Health Service Regulation

STATE FORM 5699 ZE2G11 If continuation sheet 6 of 9

| AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-----------------------------|---------------------|--|-----------------------------------|--------------------------|
| | | MHL032371 | | B. WING | | | R 14/2025 |
| NAME OF | 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 | / FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 121 | Continued From pa | ge 6 | | V 121 | | | |
| | disorders (schizoph disorders). | ed to treat certain me renia, schizoaffectiv n was used to treat b | ⁄e | | | | |
| | -Admission date of -Diagnoses of Esse Parkinson's Diseas Chronic Schizoaffer Deficiency. -Physician's orders | ential Hypertension; e; Chronic Kidney D ctive Disorder; Vitan | isease; nin D | | | | |
| | twice dailyRisperidone 4 bedtimeThe last time a six was conducted was | mg- Take one tables month psychotropics 5/7/24. ence of a current six | t daily at | | | | |
| | months of Novemb 2025 revealed: -Client #2 was adm | of client #2's MAR for er 1, 2024 through J inistered the above lovember 1, 2024 th | anuary 14, | | | | |
| | -Divalproex Sodium disorder. -Risperdal was use disorders (such as | of www.webmd.com was used to treat b d to treat certain me schizophrenia, bipol associated with autis | oipolar ental/mood ar | | | | |
| | -Admission date of | of client #3's record 3/6/24. zophrenia: Hyperten | | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZE2G11 If continuation sheet 7 of 9

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|---------------------|--|--------------------------------|--------------------------|
| | | MHL032371 | | B. WING | | I | R 14/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| ROSE'S | CASTLE RESIDENTIA | AL SERVICES INC | 505 COOP | 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| V 121 | Continued From pa | ge 7 | | V 121 | | | |
| | Dyslipidemia; Obes -Physician's orders -Aripiprazole 2 bedtimeLorazepam 1 r bedtimeTrazodone 100 bedtimeAristada Inject milliliters intramusc -The last time a six was conducted was -There was no evid psychotropic drug r Review on 1/14/25 months of Novemb 2025 revealed: -Client #3 was adm medications from N January 14, 2025. Review on 1/14/25 | dated 12/20/24: mg- Take two tablet mg- Take one tablet 0 mg- Take one tablet ion 882 mg- Inject 3 ularly every 28 days month psychotropics 5/7/24. ence of a current six | daily at daily at et daily at et daily at et daily at s.2 s. ereview x month or the January 14, arough | | | | |
| | bipolar disorder, de syndrome. It could with autism. -Lorazepam was us | pression, and Toure also treat irritability a sed to treat anxiety. | ette associated | | | | |
| | Interview on 1/14/2: -She remembered of facility in November send the forms con-She went to the phrequest them and to the facility was not staff at the pharma | npleted back to the fl parmacy this morning the person that had o | aled: ing to the iid not facility. g to come out . omputer | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZE2G11 If continuation sheet 8 of 9

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | SURVEY PLETED |
|--------------------------|---|---|---|---|------------------------------------|--------------------------|
| | | MHL032371 | B. WING | | | R 14/2025 |
| | PROVIDER OR SUPPLIER CASTLE RESIDENTIA | AL SERVICES INC 505 C | ET ADDRESS, CITY, COOK ROAD HAM, NC 27713 | 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 121 | reviews were condu-She acknowledged that the drug review Interview on 1/14/2 Professional reveal-She was aware the previously citedShe thought the period been conducted as -She confirmed the the pharmacist had months psychotrop | ucted in November. If there were no recent recovers were completed. It with the Qualified ed: In this deficiency was eychotropic drug reviews have required. If were no recent records a completed the clients' six its drug reviews. | ad that | | | |

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⁶⁸⁹⁹ ZE2G11 If continuation sheet 9 of 9