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	MHL044-068	A. BUILDING: _____ B. WING _____	C 12/02/2021

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THE BALSAM CENTER ADULT RECOVERY UNIT	91 TIMBERLANE ROAD WAYNESVILLE, NC 28786

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V 000	INITIAL COMMENTS A complaint survey was completed December 2, 2021. The complaint was substantiated (Intake #: NC00180259). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G.5000 Facility Based Crisis Service for Individuals of all Disability Groups.	V 000		
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; (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	V 118	Medication Administration is a required component of on-boarding training for all new hires to the ARU who are not already eligible to administer medications by credentialing or licensure. In the case of the 2 identified staff, there was documented evidence that the employee had been scheduled for and attended the initial training for Medication Administration, as evidenced by Google Calendar events. However, the Nurse who provided the training and was responsible for Certificates of Completion, failed to submit those certificates or document observation of staff administration; that Nurse is no longer employed with this agency and thus this error was not able to be corrected. All employees of ACS ARU (that are identified eligible) will continue to receive the in-house 3 hour medication training course with a Nurse/Qualified Trainer.	

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V 118	Continued From page 1 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure medications were administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person affecting 2 of 2 unlicensed staff audited (Staff #3 and #4). The findings are: Review on 11/30/21 of the Adult Recovery Unit Manager's employee record revealed: -Hire date of 5/10/21. -Employed as Adult Recovery Unit Manager. -No nursing degree/license. -No training documented in medication administration. Review on 11/30/21 of Staff #4's employee record revealed: -Hire date of 6/28/21. -Employed as Certified Mental Health Assistant (CMHA). -No nursing degree/license. -No training documented in medication administration. Review on 11/30/21 of level one incident reports via Google meet with the Director of Outpatient Services revealed: -There were 5 level one incident reports from July	V 118	This course includes a post-test that the facilitator administers and upon completion, will issue a certificate that will then be included in the employee's HR Record. After completion of the 3 hour medication course, the employee will be required to complete 6 supervised medication passes and will be issued a certification thereafter. Copies of both certificates will now also be made available electronically to the ARU Director as well as maintained in the employees' HR file. Facilitators shall be required to submit completed certificates/training verification within 48 hours of completing the training, and Business Operations staff shall verify that all required certificates/documents have been entered into the appropriate employee HR files via initial and routine monitoring.	

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V 118	Continued From page 2 to present. -Three reports dated 8/31/21 involved Former Clients (FC) #4, #5 and #6. -Staff #4 was listed as the staff administering the medications on the 8/31/21 reports. Interview on 12/1/21 via Google meet with the Director of Psychiatric Services to review the above MARs revealed: -FC #4 -there was no indication of a medication error on 8/31/21; Klonopin 1 mg was not administered at 10:00 a.m. and 2:00 p.m. on 8/30/21. This could have been the error referenced in the incident report. -FC #5 - Trileptal 600 mg in the a.m. - box was red and reflected it was a duplicate order; nothing was written in staff comments. -FC #6- there was no indication of any errors. Review on 12/1/21 of Narcotic Inventory Forms from August 2021 to present revealed: -The Adult Recovery Unit Manager signed as incoming and/or departing staff on: 8/10/21; 8/12/21, 10/7/21, 10/8/21, 10/9/21, 10/14/21, 10/15/21, 10/16/21, 10/21/21, 10/22/21 and 10/23/21. Review on 12/1/21 of two "House Stock" count sheets of Buprenorphine 2 mg and Buprenorphine 8 mg revealed: -The Adult Recovery Unit Manager signed the following dose administration for a non-sampled FC: 10/7/21 - 8 mg 10/14/21 - 4 mg 10/15/21 - 2 mg 10/15/21 - 4 mg 10/21/21 - 8 mg 10/22/21 - 8 mg 10/22/21 - 2 mg	V 118		

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V 118	Continued From page 3 10/23/21 - 8 mg Interviews on 11/30/21, 12/1/21 and 12/2/21 with the Director of Crisis Services revealed: -She could not locate medication certificates for the Adult Recovery Unit Manager and Staff #4 to determine they were properly trained to administer medications. -She currently had one Registered Nurse (RN) who trained the unlicensed staff. -Staff had to attend a classroom training as well as be observed by the RN before a certificate was given. -She located the email announcing to staff that medication training was scheduled for 7/27/21. -She thought the Adult Recovery Unit Manager and Staff #4 attended. -Staff should not have administered medications until they were completely trained and signed off by the RN. Review on 12/1/21 of a copy of an email entitled "Medication Administration Training on Tuesday, July 27th 9 am-12pm revealed: -The email was from the Adult Recovery Unit Manager. -Staff #4 was listed as a recipient of the email. -The Adult Recovery Unit Manager wrote in the email they would cover Staff #4's shift as CMHA on the morning of the training since Staff #4 was scheduled to work.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or	V 123	The procedures regarding medication administration, including but not limited to the use of the electronic MAR and noting of medication errors (type of error, any reported side effects, notification of pharmacy/admin), and Incident Reporting are provided	

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V 123	Continued From page 4 pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure drug administration errors were reported immediately to a physician or pharmacist and an entry of the drug administered and the drug reaction were properly recorded in the drug record affecting 4 of 4 former clients audited (FC#4, #5, #6 and #7). The findings are: Review on 11/30/21 of level one incident reports via Google meet with the Director of Outpatient Services revealed: -There were 5 level one incident reports from July to present involving medication errors. -Three of the reports dated 8/31/21 involved FC's #4, #5 and #6. -The report reflected medications were not given to the above clients and the supervisor was called. -There were no details listed as to what medication was missed, why it was missed, and if there was any outcome/side effect. -A second report dated 8/31/21 for FC #5 did not list the medication not given and any outcome/side effect. -A fifth report dated 10/26/21 for FC #7 indicated a wrong dose of Subutex was given. -There was no explanation of what dose was given, why the error occurred and if there was	V 123	during initial orientation training and are also detailed in Policies and Procedures. The staff referenced in these exceptions were verified to have received referenced training and had access to Policies and Procedures. In accordance with this rule: All nurses, CMA's and all Certified CMHA's will be retrained in medication reporting and documentation. Re-training at minimum will include Medication Administration Module and Incident Reporting Module assignments in Relias Training System. Additional individual training, live training/supervision, and/or other training modules may be assigned if specific staff are identified through the retraining process as having continued challenges. This retraining will be completed for all staff no later than 2/28/2021. Specifically, nurses will be reminded to sign off and document in their EHR documentation that they have contacted the Physician, Pharmacy, and any other relevant persons to conduct appropriate notification, in addition to completing all other required elements within electronic MAR relative to errors and exceptions. Program Supervisors will also be reminded to review the MAR as part of their review following receipt of Medication Error Incident Reports from staff. Specifically, they will be reminded to contact the staff, Program Director,	

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V 123	Continued From page 5 any outcome/side effect. -Each report had a box to check if the pharmacy or physician was contacted; the boxes were not checked on any of the above incidents. Interview on 11/30/21 with the Director of Outpatient Services revealed: -She was in charge of receiving the incident reports and determined if they needed to be put into the system at a higher level. -The second report on FC #5 may have been a duplicate. -None of the above reports were entered as a level II so she must have determined the pharmacy/physician was called. Interview on 11/30/20 with the Director of Crisis Services revealed: -the notification to the pharmacy/physician should be located on the Medication Administration Records (MARs). Review on 12/1/21 of FC #4's MAR dated August 2021 revealed: -No exceptions or staff notes were documented on 8/31/21 and no pharmacy/physician notification. -On 8/30/21 Klonopin 1 milligram (mg) 4 times a day - 10:00 a.m. and 2:00 p.m. dose reflected "not available." Review on 12/1/21 of FC #5's MAR dated August 2021 revealed: -A blank on 8/31/21 for Trileptal 600 mg daily at 10:00 a.m. -A note at the top of the box under "Scheduled Slots" reflected "duplicate order client was only given 600 mg x 1 this morning at 1000." -There was no indication if the note was related to the 8/31/21 blank.	V 123	and/or Medical Director to ensure appropriate review and follow-up on each reported error.	

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V 123	Continued From page 6 -There were no other staff comments noted or any notification to the pharmacy/physician. Review on 12/1/21 of FC #6's MAR dated August 2021 revealed: -No indication of a medication error on 8/31/21 thus no exception notes of any kind. Review on 12/1/21 of FC #7's MAR dated October 2021 revealed: -Subutex 2 mg - 2 times a day at 10:00 a.m. and 4:00 p.m. -10/26/21 at 4:00 p.m. reflected "On Hold." -There were no staff notes as to why the Subutex was held, if the pharmacist/physician was called and any outcome/side effects.	V 123		