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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 1/26/24. The complaints were substantiated (NC#00210955, NC#00210966, NC #00211794). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G.4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G.5000 Facility Based Crisis Services for Individuals of all Disability Groups. This facility is licensed for 16 and currently has a census of 6. The survey sample consisted of audits of 4 current clients and 2 former clients.	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	V 105		

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V 105	Continued From page 1 problem or need; (B) an assessment of whether or not the facility 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		

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This Rule is not met as evidenced by:
Based on record reviews, interviews and observation, the facility failed to develop and implement adoption of standards that ensure operational and programmatic performance meeting applicable standards of practice. The findings are:

Review on 1/12/24 of Possession of Controlled Substances policy effective 5/17/16 revealed:
-" ...All controlled substances must be stored separately in a locked cabinet within a locked cabinet ...A register must be kept for the possession of all controlled substances. The register is to include (A) name of the medication (B) dose (C) preparation (D) date and time received (E) amount received (F) client name (G) prescribing practitioner (H) signature of designated medical staff that received the medication (I) signature of the designated medical staff that dispensed the medication; the register must include a working total count; the register must be counted at each log entry; the register must include two signatures noted above ..."

Record review on 1/8/24 for Former Client (FC) #5 revealed:
-Date of admission: 9/21/23
-Date of discharge: 12/29/23
-Diagnoses: alcohol use disorder, opiate use disorder, methamphetamine use disorder, depressive disorder, anxiety disorder,

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post-traumatic stress disorder, treatment resistant hypertension.
-Evaluation and management notes:
-12/14/23 signed by the Former Medical Director (FMD) - "Methadone continued 2 days extra in error, so he received his last dose today. He reports many vague side effects and ascribes all of them to starting buprenorphine and withdrawing from methadone. He denies the typical withdrawal symptoms from opioids and specifically denies muscles aches, GI (gastrointestinal) symptoms, hot and cold sweats or restless legs. He stated he is unable to feel his feet, feels unsteady, feels in a dissociated state, that he is unable to breathe and that it feels like something is stuck in his throat. He denies throat pain and is able to swallow. He does sound like he may be wheezing and breath sounds are reported as diminished on auscultation ..."

-Methadone control count sheets:
-10/12/23 with five 75mg (milligram) doses,
-10/16/23 four 75mg doses,
-12/13/23 seven 80mg doses (signatures indicated there were 9 doses administered),
-12/19/23 seven 80mg doses (dates initialed as administered 12/22/23-12/28/23)

-Chain of custody records for transfer of methadone from FC #5's OTP (opioid treatment program) to the facility:
-11/9/23- 6 doses but no signature of person receiving methadone.
-12/19/23 -7 doses but no signature of person receiving methadone.

-Dosing history from the OTP from 10/11/23-12/19/23:
-10 weeks of "take out" doses delivered to the facility totaling 71 doses.

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-There were no count sheets or chain of custody documents to verify how much methadone was received or maintained in the facility for 48 doses that were delivered from the OTP.

Record review on 1/8/24 for FC #6 revealed:
-Date of admission: 12/10/23
-Date of discharge: 12/15/23
-Diagnoses: opioid use disorder, cannabis use disorder, sedative use disorder, methamphetamine use disorder, depressive disorder, anxiety disorder.
-Physician ordered medications dated 12/10/23 included:
-Methadone 120mg-(opioid use treatment) 1 dose daily.

Review on 1/10/24 of FC #6's MAR (medication administration record) from 12/10/23- 12/15/23 revealed:
-Methadone was initialed as administered daily.

Review on 1/10/24 of chain of custody record from a local OTP dated 12/11/23 for FC #6 indicated 7 methadone doses of 120mg were delivered to the facility on 12/11/23.

Interview on 1/16/24 with the Program Director at the OTP revealed:
-She and their nursing supervisor delivered 7 bottles of methadone on 12/11/23 to the facility for FC #6 and had facility staff signed their chain of custody document.

Review on 1/16/24 of an email dated 12/15/23 regarding FC #6 from Former Registered Nurse (FRN) #3 revealed:
-" ...We discharged a shared client today who will need methadone dosing tomorrow morning

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V 105	Continued From page 5 (12/16) as they did not leave with two of their doses ..." Review on 1/16/24 of internal incident reports revealed: -dated 12/14/23 from FRN #3 -"There are 4 discrepancies this morning for controlled substances. (1) Client Specific Methadone for [FC #6]; sheet said there should be 4 doses left, there were only 2 doses. (2) Client Specific Methadone for [FC #5]; sheet said there should be 5 doses left and there are 7 doses. (3) Bup (buprenorphine) 2mg card #...'Card 1'; sheet said there should be 7 tablets, there were only 5 tablets. (4) Bup 2mg card #...; sheet said there should be 5 tablets, there are 6 tablets. Because of the count being off by 2 for both (1) and (2), it's possible that [FC #5] was overdosed. [FMD] notified." -dated 12/15/23 from RN #2 regarding FC #5 - "methadone was given 2 mornings, 12/13 and 12/14 (2023). The methadone dose should have been stopped on 12/13. The medication appeared on the MAR to be given each morning. The order was to stop the dose on 12/13/23. When the order was placed in the MAR the stop date was put in as 12/23/24, therefore it appeared as a current order and appeared on the MAR..." Record review on 1/10/24 of narcotics count sheets revealed: -The counts followed numeric descending order as each medication was signed as administered. -Lorazepam 1mg tablet dispensed on 7/20/22 with expiration date of 7/20/23. -The count went from 5 (administered on 1/1/24) to 3 (administered on 1/5/24). There was no #4 indicating a tablet was missing. -Buprenorphine 2mg tablet dispensed 11/30/23.	V 105		

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-On 12/11/23 the count was 4 tablets.
-On 12/14/23 the count was 5 tablets.
-Phenobarbital 15mg tablet dispensed 5/22/23.
-On 10/22/23 the count was 6 tablets.
-On 10/26/23 the medication blister pack card was missing.

Record review on 1/10/24 of picture of buprenorphine blister pack showing a small ink mark and puncture in the corner of the #6 tablet foil on back of the card. The plastic on front of the card for #6 tablet did not appear to be depressed but the tablet is not there.

Review on 1/25/24 of facility's narcotics inventory form revealed lines for 2 staff to sign to attest they had counted narcotics. (There were no specific medications listed) The form included date, time (either 8am or 8pm), departing staff signature and arriving staff signature. Of the 180 entries between 10/20/23-1/18/24 there were 76 entries that had only 1 signature.

Interview on 1/11/24 with Staff #4 revealed:
-Worked there almost 8 years.
-She administered medications. Do med (medication) counts at the end of shift. "I recount to confirm their numbers. Haven't found any discrepancies when I've counted. There have been times where there was a (medication) card or no (control) sheet but it's been a while." She would inform the nurses and the directors of any discrepancies.

Interview on 1/10/24 and 1/18/24 with RN #1 revealed:
-The CMHAs (community mental health assistants) sat in the nurses station when working overnight with access to all medications.
-"Since September (2023) the MARs and control

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V 105	Continued From page 7 counts went berserk." -"The clinic [FC #5's OTP] delivered (methadone) to the Balsam Center weekly. CMHAs would check it in and sometimes leave it sitting on top of the med cart." -Had informed Director of Enhanced Services (DES) and Director of Operations (DOO) on 11/27/23 she felt Staff #4 was diverting medications. -"[FMD] and I took a picture on 12/11/23 of a bup (buprenorphine) card that had a slit in the back with the tablet missing. [FMD] talked to administration." -"This place isn't safe. There's no medical director and not enough nurses. [Former Director] never left us without a nurse ..." -"[FMD] sent an email 12/13/23 to [DOO] reporting missing meds, count discrepancies, incorrect dosing and was not back in the office until 12/18/23 when she was terminated." Interview on 1/16/24 with RN #2 revealed: -FC #5 methadone provider "would deliver it and drop it off to us; usually 7 days worth ...would lock it in the control box in the cart ...would read the bottle and hand him the bottle and he would read it. His plan was to start bup to wean off methadone ..." -"I don't think [FC #5] got [FC #6]'s methadone. -"Told the [DOO], 'you don't have any idea what's in these medication carts.' CMHAs are going to start giving meds after they fired [former director]. Told her right from the get go it was a bad idea, they don't know what the meds are for." -"I think counts of controls got so screwed up due to diversion but can't prove it. Me and [RN #1] look back over everything. We used to do it together. There was a pill missing in the middle of this card ...the plastic was not depressed. [RN #1] reported to the [DES]."	V 105		

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-"Try to be careful with everything. It's difficult to go behind others who aren't doing things the same way."
-Now the facility doesn't admit anyone on methadone or buprenorphine even if they supply their own doses.
-There's no actual physician on site like [FMD].
-"We're counting narcs (narcotics) when we come on and leave. CMHAs are also supposed to count. Whoever has been taking these medications is probably still there taking medications ...Administration has been notified [RN #1] has notified them. They have not confronted any specific person. Should have done this weeks ago ...put them on leave until investigated. The person is still employed, giving meds with the keys to the kingdom. It's not my place to confront that person."
-"It's been a persistent problem and administration is closing their eyes just to keep us open. I don't know what to tell you. If I do something wrong, I do an incident report and own it. Don't know what else to do. If you suspect someone of taking these meds, investigate and then let them go."

Interview on 1/25/24 with FRN #3 revealed:
-He worked 3 days a week and off for 4 days. "When I would come back there'd be multiple discrepancies (in the narcotics counts)." Reported to the former director before she left and then to the [DES]. "Nothing changed; seemed my concerns were not taken seriously."
-"Believed 100% that staff was stealing narcotics" and a coworker believed staff was taking non-narcotic medications.
-Concerned facility was using med techs (medication technicians) with dangerous medications. "I was concerned for mine and clients' safety as well as legal liability."

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-"Management would give lip service but nothing happened immediately". Notified FMD.
-"When I started I would always do the (controlled medication) count alone; not a shared (2 person) count . Would sign saying 'I have conducted controlled count' log. Don't document on the count sheet until administered."
-The new unit director (DES) "started us initialing on the card when we administered and sent out a lot of eLearning on medications."
-"Techs (CMHA) didn't want to do this (administer medications), they were made to."

Interview on 1/25/24 with the FMD revealed:
-"No system in place to be notified for each count that was off. Conversations sort of moved to [DOO]. Nothing was happening to correct the system."
-The director of nursing position was eliminated. "It was not my responsibility to see that counts were getting done. Supposedly this was in the middle of being investigated when told we have to look at the tapes (camera recordings). No changes were made. There was a general sense of things are falling apart."
-"Double doses, subversion, not knowing where drugs are going; it was too dangerous for clients."

Interview on 1/8/24 with the DES revealed:
-Mid November "there was no control count being done; not counting at shift change; medications were being left out."
-Able to review camera footage of medication passes. Added trainings.
-Dealt with lots of staffing issues, scheduling, putting out fires. Previously there was a lot of mismanagement; poor direction, lots of medication errors so lots of retraining going on.

Interview on 1/10/24 and 1/25/24 with the DOO

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V 105	Continued From page 10 revealed: -Regarding FC #6 methadone, "the correct procedure was not followed and don't know if he was discharged with it and it went missing or if it was missing prior to discharge. Don't know if he actually came in with it. Reported 1/8/24; conducting investigation now." -"Never found FC #6's 2 doses of methadone but there was no evidence of diversion. FC #5 was administered 2 additional doses of methadone but they were his 80mg." -"RN #1 was pulling count sheets out of the narc (narcotics) book and putting them in a separate folder to report to FMD but as far as I know no investigation was completed. When we did our compliance investigation, these count sheets were not in the narc book. We have reopened the investigation." -"FMD made call in mid December and current Medical Director again reiterated on 12/21/23 that we will no longer accept methadone clients and will utilize Ativan protocols no longer using phenobarbital for alcohol detoxification to reduce the number of controls in stock so nursing could track more easily." -The medication carts were supposed to have monthly inventory. "Don't know what happened." -Redesigned who was allowed into the nurses station; "restricted access for those staff that were not medication trained." Magnetic locks register number on staff badge and number of door and can remove authorization for specific room. -All CMHAs were now trained to pass medications as of 1/5/24. -FMD was a contracted employee and her contract ended. This deficiency is cross referenced into 10A NCAC 27G.0209 Medication Requirements	V 105		

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V 105	Continued From page 11 (V118) for a Type A1 violation and must be corrected within 23 days.	V 105		
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 record reviews and interviews, the facility failed to hold fire and disaster drills on each shift at least quarterly. The findings are: Review on 1/10/24 of fire and disaster drills for January-December 2023 revealed: -There was no documentation of fire drills having been conducted on 1st shift (day shift 8a-8p) in the quarter from January-March 2023 or on 2nd shift (overnight shift 8p-8a) in the quarter from October-December 2023. -There was no documentation of disaster drills having been conducted on 1st shift (day shift) in the quarters from July-September 2023,	V 114		

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V 114	Continued From page 12 October-December 2023 or on 2nd shift (overnight) in the quarters from January-March 2023, April-June 2023, July-September 2023, October-December 2023. Interview on 1/10/24 with Director of Operations revealed: -Facility ran 12-hour shifts (8a-8p and 8p-8a). -There was a master schedule for drills in front of the drill book. -"Fire/disaster drills were usually run back-to-back but were not recorded correctly." -She was not sure why the previous facility director had not conducted drills or if she did, where she might have documented them.	V 114		
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;	V 118		

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V 118	Continued From page 13 (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 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 record reviews, interviews and observation, the facility failed to ensure medications were administered on the written order of a physician and that MARs were kept current affecting 3 of 4 audited clients (#1, #2, and #4) and 2 of 2 audited former clients (FC #5, #6). The facility also failed to assure staff (former staff (FS) #7 and Former Registered Nurse (FRN) #3) were competent to administer the correct medications, unexpired medications and transcribe verbal orders as given. The findings are: Cross Reference: 10A NCAC 27G.0201 Governing Body Policies (V105). Based on record reviews and interviews, the facility failed to develop and implement adoption of standards that ensure operational and programmatic performance meeting applicable standards of practice. Cross Reference: 10A NCAC 27G.0209 Medication Requirements (V119). Based on	V 118		

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record reviews, interviews and observation the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 2 of 4 audited clients (#1 and #4).

Cross Reference: 10A NCAC 27G.0209 Medication Requirements (V123). Based on record reviews and interviews, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 3 of 4 audited current clients (#1, #2, #4) and 1 of 2 audited former clients (FC #5).

Finding #1 - Medications being administered without the written order of a physician and MARs not being kept current.

Record review on 1/8/24 for Client #1 revealed:
-Date of admission: 12/28/23
-Diagnoses: alcohol use disorder, opiate use disorder, attention deficit hyperactivity disorder (ADHD), major depressive disorder, anxiety disorder.
-Physician ordered medications included:
  -Multivitamin (supplement) - 1 tab (tablet) daily ordered 12/28/23.
  -Flexeril 10mg (milligram) (muscle cramps) - 1 tab every 6 hours PRN (as needed) ordered 12/29/23.
-There was no order for Adderall 10mg.

Review on 1/9/24 of MARs from 12/28/23-1/9/24 for Client #1 revealed:
  -Multivitamin was initialed as administered on 12/29/23 three doses, 12/30/23 three doses and 12/31/23 two doses. (8 doses)
  -Flexeril was initialed as administered on 1/4/24 at 12:30pm, 4:30pm (4 hours apart) and 7:30pm (3 hours apart); on 1/6/24 at 9:00am,

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1:00pm (4 hours apart), 4:13pm (3 hours apart).
-Adderall 10mg (ADHD) -1 tablet once daily at 11am was initialed as administered 12/29/23, 12/30/23, 1/1/24, 1/3/24. (4 doses)

Record review on 1/8/24 for Client #2 revealed:
-Date of admission: 12/31/23
-Diagnosis: alcohol use disorder
-Physician ordered medications dated 12/31/23 included:
-Multivitamin (supplement) - 1 tablet daily.

Review on 1/9/24 of MARs from 12/31/23-1/9/24 for Client #2 revealed:
-Multivitamin was not documented as administered on 1/6/24.

Record review on 1/10/24 for Client #4 revealed:
-Date of admission: 1/5/24
-Diagnosis: alcohol use disorder
-Physician ordered medication dated 1/5/24 included:
-Lorazepam 1mg (alcohol withdrawal symptoms) - give 4 times daily for 2 full days.

Review on 1/10/24 of MAR from 1/5/24-1/9/24 for Client #4 revealed:
-Lorazepam was not documented as administered on 1/7/24 at 10pm dose.

Record review on 1/8/24 for FC #5 revealed:
-Date of admission: 9/21/23
-Date of discharge: 12/29/23
-Diagnoses: alcohol use disorder, opiate use disorder, methamphetamine use disorder, depressive disorder, anxiety disorder, post-traumatic stress disorder, treatment resistant hypertension.
-Physician ordered medications included:
-Buprenorphine 8mg (opioid use disorder) - 1

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tablet twice daily ordered 12/8/23.
-Amitriptyline 100mg (depression) - 1 tablet at bedtime ordered 11/6/23.
-Meloxicam 7.5mg (pain) -1 tablet twice daily ordered 11/11/23.
-Gabapentin 300mg (pain)- 1 capsule 3 times daily ordered 11/22/23.
-Hydralazine 50mg (hypertension) -1 tablet 3 times a day with meals ordered 11/22/23.
-Lisinopril 20mg (hypertension) - 1 tablet twice a day at breakfast and at bedtime ordered 10/20/23.
-Seroquel 12.5mg (depression) -1 tablet 3 times a day with meals ordered 11/27/23.
-Metamucil Powder (fiber supplement) -2 tablespoons twice daily ordered 9/23/23 .
-Methadone 80mg (opioid use disorder) 1dose daily ordered on 11/4/23 from 75mg ordered 9/20/23.

Review on 1/10/24 of MAR from 11/1/23-12/29/23 for FC #5 revealed:
-Buprenorphine was not documented as administered 12/14/23 pm dose.
-Amitriptyline was not documented as administered on 12/2/23.
-Meloxicam was not documented as administered on 12/2/23 pm dose.
-Gabapentin was not documented as administered on 12/2/23 pm dose.
-Hydralazine was not documented as administered on 12/2/23 7:30am dose or 12/6/23 4:30pm dose.
-Lisinopril was not documented as administered on 12/2/23 pm dose.
-Seroquel was not documented as administered on 12/3/23 7am dose.
-Metamucil was not documented as administered on 12/2/23 pm dose.
-Methadone was not documented as

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administered on 12/3/23.

Finding #2 - Staff competency during medication administration and transcribing orders.

Record review on 1/12/24 for former staff (FS) #7 revealed:
-Date of hire: 6/28/21 as CMHA (community mental health assistant)
-Date of separation: 12/19/23
-Medication administration trained

Record review on 1/12/24 for former registered nurse (FRN) #3 revealed:
-Date of hire:7/21/23
-Date of separation: 12/21/23

Review on 1/10/24 of an internal incident report dated 11/27/23 regarding FC #5 revealed:
-"Sunday November 26th, 2023 there were three CMHAs on duty, [Staff #6], [FS #8] and [FS #7], RN (registered nurse) on call [RN #1].
-At 11:45am RN (RN #1) notified CMHA [FS #7] who had called in reference to [former client (FC) #7] needing to be started on Subutex 8mg SL (sublingual) now. RN signed out the Subutex/bup (buprenorphine) in the MAR. Instructed [FS #7] to give to [FC #7] now that was done at 11:28am.
-At 11:51am [FS #7] signs out two Tylenol for [FC #5] for his chronic headaches. 1:07pm [FS #7] calls RN again to notify her [FC #5] is having crushing chest pain, SHOB (shortness of breath), severe panic, paranoia and severe hypertension. At the time of the call [FS #7] never noted to RN two Subutex/bup were missing. Nor that they were found behind the Tylenol tab. (2 subutex/bup missing) (when Tylenol is given two 325mg are given) 2 hours later [FC #7] was c/o (complaining of) crushing chest pain. (CMHA never put two and two together? Never thought

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V 118	Continued From page 18 to report to RN while explaining [FC #5]'s new onset of sudden symptoms. -[FC #5] was sent to [local medical center] with hypertension and severe panic and paranoia 1:30pm. 8:00pm [FC #5] returned from the [local medical center] and was diagnosed with Severe Panic attack. -Monday November 27th, 2023 at 9am [RN #1] is then notified that two Subutex/bup 8mg are missing and were found behind the Tylenol card. This led RN to believe a patient could have been given Subutex/bup 16mg instead of Tylenol 650mg. RN immediately notified MD (Medical Director) and admin (administration) and administered UDS (urine drug screen) cups to every client to see who is positive for bup and should not be. [FC #5] was positive for Bup (which is not prescribed) and MTD (methadone) which he is prescribed. Buprenorphine and methadone are contraindicated with each other and sent client into precipitated withdrawals. -Nothing was done for the mistake because it was not reported to the nurse that two narcotics were missing and the Subutex card reportedly was put 'behind the Tylenol card' and [FC #5] takes routine Tylenol. Two white tablets that appear to look like the Subutex 8mg white tablet were given to the patient as evidenced by his positive UDS for BUP and the timeline of signed out Tylenol and the report of where the missing Subutex/bup card was found in the Tylenol slot missing #2 which is the amount of Tylenol that is to be given. -As [Former Medical Director (FMD)] stated not having CMHAs administering medications especially narcotics would cut out these major errors. -11/27/23- 10am -Do not allow CMHA to give any medications or be in the nurses station per	V 118		

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[FMD]."

Review on 1/18/24 of an email from FMD to the Director of Operations (DOO), Nurse Practitioner (NP) and RN #1 on 12/13/23 revealed:
-" ...Since our nursing/CMA (Certified Medical Assistant) staffing has dwindled and CMHAs have started to dispense medication, we have had, and are continuing to have the following incidence;
-A patient received his methadone 70mg dose twice in one morning.
-Buprenorphine was not returned to the narcotics box, filed behind acetaminophen and when a patient, who was on methadone, requested acetaminophen, they received buprenorphine 16mg in addition to their methadone dose. In a patient who had never taken narcotics this dose of buprenorphine could have led to overdose and death. In this case, the patient developed severe chest pain and required transfer to the emergency room.
-Narcotics are not signed out consistently by staff dispensing them.
-The narcotics count performed by nursing staff at the beginning of their shifts shows missing tablets.
-A medication card has been found where the back was carefully punctured by a ball-point pen (noted by the pen marks on an enlarged photo) and buprenorphine tablet was removed, indicating subversion of narcotics ..."

Additional record review on 1/16/24 for FC #5 revealed:
-Evaluation and management (E/M) notes:
-12/14/23 signed by the FMD - "Methadone continued 2 days extra in error, so he received his last dose today. He reports many vague side effects and ascribes all of them to starting

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buprenorphine and withdrawing from methadone. He denies the typical withdrawal symptoms from opioids and specifically denies muscles aches, GI (gastrointestinal) symptoms, hot and cold sweats or restless legs. He stated he is unable to feel his feet, feels unsteady, feels in a dissociated state, that he is unable to breathe and that it feels like something is stuck in his throat. He denies throat pain and is able to swallow. He does sound like he may be wheezing and breath sounds are reported as diminished on auscultation ..."

-Additional orders revealed:
-Order dated 12/8/23 revealed:
"Start Suboxone Titration as follows:
1) Give buprenorphine 1/2mg SL (sublingual) now. (Give 1/4 of 2mg tab).
2) Tomorrow, 12/9/23, give BUP (buprenorphine) 1mg SL in AM.
3) On 12/10/23, give BUP 2mg SL in AM.
4) On 12/11/23, give BUP 4mg SL in AM.
5) On 12/12/23, give BUP 8mg SL in AM.
6) On 12/13/23, start BUP 8mg SL BID and continue this dose daily. STOP METHADONE."
-Verbal order dated 12/14/23 with physician's signature revealed:
"One time dose of Methadone 80mg on 12/15/23"
-Verbal order clarification dated 12/14/23 without physician's signature revealed:
"for 12/15/23, give methadone 80mg,
give 8mg Buprenorphine in qAM (once a day in the morning) and then 8mg of buprenorphine at noon."
-Verbal order dated 12/16/23 without physician's signature revealed:
"Give methadone 80mg solution PO (by mouth) once now.
Methadone solution PO 80mg once at noon 12/17/23.

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Methadone solution PO 80mg qAM starting 12/18/23.
Discontinue current buprenorphine order.
Buprenorphine 8mg PO qAM on 12/17/23 and 12/18/23
Buprenorphine 4mg PO qAM on 12/19/23 and then discontinue buprenorphine."
-There was no order to dose methadone on 12/14/23.

Interview on 1/11/24 with Staff #1 revealed:
-"[FS #7] passed Subutex (buprenorphine) thinking it was Tylenol- it could have killed one of us. It (buprenorphine) was not in the lock box (for controlled medications)."

Interview on 1/10/24 and 1/18/24 with RN #1 revealed:
-Had been a RN on the unit since May 2020.
-"CMHAs were left here to do meds (medications)." There were lots of medication errors, missing medications and medications being put in the wrong places. "One CMHA working overnight was moving buprenorphine and Tylenol around. FC #5 was thrown into withdrawal pains when given what staff thought was 2 Tylenol."
-The Nurse Practitioner would give verbal orders to CMHAs to administer a medication before RN #1 saw the order and added it to the electronic MAR. These medications could not be documented when given as they were not on the MAR yet. CMHAs signed the MARs late but the medication in the eMAR didn't stay highlighted (to indicate a late/missed dose). "The MAR is timestamped, but I would have to look at each medication each time stamp. We have no nurse manager and me and [RN #2] don't have time to review."

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Interview on 1/16/24 with RN #2 revealed:
-Had been at facility for 4 years.
-"I gave [FC #5] methadone 2 extra days. [FMD] asked 'why did you administer? I gave specific instructions to discontinue methadone. Why is it still on the MAR?' Who ever put that order in mistakenly put as 2024 rather than 2023."
-"[FS #7] who was working was real upset (after giving FC #5 buprenorphine instead of Tylenol). One card was standing up and hadn't been shoved all the way down ...bup (buprenorphine) was in behind Tylenol tag ...pills looked very similar. I told the doctor and put it in the narc box. She [FS #7] never liked giving meds anyway."
-"[Former RN (FRN) #3] gave [FC #5] and an additional 2nd dose of methadone in a day. I told him I already gave him (FC #5) his daily dose of methadone this morning. He should have had an incident report."

Interview on 1/25/24 with FRN #3 revealed:
-"Remembered giving [FC #5] a second dose of methadone ...informed [FMD]." Did not recall completing an incident report but probably did.

Interview on 1/25/24 with the FMD revealed:
-"FC #5 was complicated. Fairly new method to get someone off methadone quickly; it was usually a long process ...there was a push to get him out and there was nowhere for him to go being on methadone. He didn't do well on this protocol and then got continued on methadone."
-Was aware FC #5 was double dosed on methadone. "I think it was early November. Medications were not properly signed out. Horribly short staffed."

Finding #3 - Administration of 15 doses of expired Lorazepam.

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Record review on 1/8/24 for Client #1 revealed:
-Date of admission: 12/28/23
-Diagnoses: alcohol use disorder, opiate use disorder, attention deficit hyperactivity disorder, major depressive disorder, anxiety disorder.
-Physician ordered medication dated 12/28/23 included:
-Lorazepam 1mg - alcohol detoxification protocol -1 tab let 4 times a day for 2 days, 1 tab 3 times a day for one day, 1 tab two times a day for one day then 1 tab one time on last day of taper.

Review on 1/9/24 of MAR from 12/28/23-1/9/24 for Client #1 revealed:
-Lorazepam was documented as administered on 12/28/23 at 5:30pm and 9pm; on 12/29/23 at 8am, 11am, 4pm and 9pm; on 12/30/23 at 10am, 4pm and 9pm; once on 12/31/23 and once on 1/1/24.

Record review on 1/10/24 for Client #4 revealed:
-Date of admission: 1/5/24
-Diagnosis: alcohol use disorder
Physician ordered medication dated 1/5/24 included:
-Lorazepam 1mg- alcohol detoxification protocol-1 tab 4 times a day for 2 days, 1 tab 3 times a day for one day, 1 tab two times a day for one day then 1 tab one time on last day of taper.

Review on 1/10/24 of MAR from 1/5/24-1/9/24 for Client #4 revealed:
-Lorazepam was documented as administered 1/5/23 at 6pm and 10:30pm and on 1/6/24 at 9am and 2pm.

Record review on 1/10/24 of control count sheet for house stock Lorazepam 1mg tablet dispensed

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on 7/20/22 with expiration date of 7/20/23 revealed:
-Client #1 was administered 11 tablets between 12/28/23 and 1/1/24.
-Client #4 was administered 4 tablets between 1/5/24 and 1/6/24.
-The last tablet was administered to Client #4 on 1/6/24.
-There were zero tablets remaining on this count sheet and there was no blister pack card to match this control sheet.

Finding #4 - Lack of medication administration training for overnight staff who worked alone.

Record review on 1/10/24 for Staff #5 revealed:
-Date of hire: 11/20/23 as CMHA

Interview on 1/8/24 with Client #1 revealed:
-Only 1-2 staff on duty, mostly just 1.
-"Staff person here sometimes that can't give meds but not every night."
-Had a fused ankle and was in constant pain. Broke it years ago then it was crushed in an accident.
-Was given wrong medication once, at night before nurse left at 10pm. He felt differently ...went back to the technician who called the nurse who said the medications given were in the computer and it was right. He didn't want to get anyone in trouble and would not talk about it any further. "No everything has been good. There was no mistake. It was just me."

Attempted interview on 1/9/24 was unsuccessful due to FC #5 not having a phone or consistent housing.

Interview on 1/11/24 with Staff #1 revealed:
-Hired July 2022 as a CMHA.

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-"Haven't got adequate staffing; don't have enough people to pass meds; meds missing; counts off ...told us we had to learn to pass meds ..."
-Client #1 asked for Tylenol every 4 hours. Staff #5 worked alone Thursday night and was not able to administer medications because she was not trained in medication administration.
-"When I came in Friday, all the clients were lined up to get PRN meds cause no one got anything overnight."
-"[FS #7] passed Subutex (buprenorphine) thinking it was Tylenol. It could have killed one of us. It (buprenorphine) was not in the lock box (for controlled medications)."
-Staff #5 worked overnights (8p-8a) and had to stay once until 1-2pm because no one came in to relieve her. There would have been no one here to administer medications.

Interview on 1/10/24 with Staff #3 revealed:
-Started March 2023 as a CMHA.
-There was a new female staff working overnight by herself. "She (staff #5) is not med trained ...Patients have to go without meds (medications) until someone can get here to give it ..."

Interview on 1/12/24 with Staff #5 revealed:
-Worked at facility about 3 months. Worked mostly by herself.
-"Had a short period of training before I was put on the floor by myself. I don't know everything I'm supposed to do. I feel unequipped to work by myself."
-Had not completed training in medication administration and was unable to administer medications.
-"Clients have aches and pains. Each night 2 or 3 ask for pain meds like requip for cramps, Tylenol, ibuprofen or PRNs like trazodone,

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V 118	Continued From page 26 seroquel or serotonin. If it's significant, I call [RN #1] for a quick answer. Coworkers (Staff #1 and #4) have stayed to pass (administer) scheduled meds." -"[RN #1] has come in twice for AMA (against medical advice) discharge or medication related issue." -"I didn't have any keys for a long time. Haven't needed access to any supplies (in nurses station) so far but have keys from my friend who left (no longer works there)." -"Yes, I have access to the nurses station/medication room." -"Last Saturday night (1/6/24) I worked 8p to 8a. The schedule was cut and pasted from the week before. [Staff #6] was on schedule but hadn't turned in his notice the week before. He didn't come in. Tried to call MCM (mobile crisis management) dispatch. She came over to help a little while but isn't med trained either. [RN #1] was on call but she was out of town. [RN #2] just happened to drop in around 2am to do some online training. She passed morning meds but left to sleep. Called [Director of Enhanced Services (DES)]. First, she didn't answer then it took a while to get a call back. She expected me to stay the whole time so I was at work about 20 hours." -No one was at the facility that could administer medications. Interview on 1/10/24 and 1/18/24 with RN #1 revealed: -Staff #5 worked by herself Thursday, Friday and Saturday nights. She had not yet trained Staff #5 in medication administration. -"[NP] calls and gives verbal orders to CMHAs to administer a med before I have a chance to add it to the MAR. I can't keep up with everything. The MAR is timestamped, but I would have to look at	V 118		

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each medication each time stamp. We have no nurse manager and me and [RN #2] don't have time to review."
-The CMHAs sat in the nurses station when working overnight with access to all medications.

Interview on 1/16/24 with RN #2 revealed:
-Staff #5 was new and worked alone, "I had a fit over that...this 20-year-old alone in the building; she's just a kid....I decided to go in around 2am to do the online training in the CMHA office. [Staff #5] was sitting in the nurses station when I arrived. Two and a half hours later figured this kid was by herself. No nurse was scheduled for day shift. Patients were mad cause they couldn't get meds like trazadone, Vistaril and ibuprofen. Had a nurse on call but didn't write who is the nurse on call. [RN #1] was [out of town about 2 hours away]. I don't mind to stay or to help but lets get people in." Left messages for the [DES]. "She never got back with us till 1:30 in the afternoon."

Interview on 1/25/24 with the FMD revealed:
-Was aware of the medication discrepancies. RN #1 and Former RN #3 report to her and she reported to the DOO and DES. "They told me 'they were doing investigations and I wasn't privy to that information'."

Interview on 1/8/24 with the DES revealed:
-Started in October 2023.
-Usually had 4 full time nurses and now only have 2. Down to 6-8 direct care staff.
-"Intentionally keeping census low due to staffing."
-CMHAs go through medication administration training. RN #1 does the training but depends on her availability for training.
-"Don't always have a nurse on duty. They are on

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call but med techs (CMHA) can pass standing orders."
-"Heard about [FC #5] here before but he was readmitted. He was here for 80 days; issues with his discharge; med error where staff gave him bup instead of Tylenol. [FC #5] went to the emergency room. Those 2 staff were put on administrative leave pending outcome; 1 staff member who gave the wrong med quit and the other one left shortly after."

Interview on 1/10/24 and 1/25/24 with the DOO revealed:
-RN #1 and RN #2 noticed that FRN #3 missed counts.
-Staff #5 had medication training but had not been cleared to pass yet. When Client #1 needed Tylenol, Staff #5 should have called RN #1 and she should have come in to pass med. Don't know why that didn't happen. Has asked that Staff #5 not be on shift alone.
-Sometimes day shift CMHAs stay until 10pm to help out.
-"RN #1 has never been by herself watching the unit and completing admissions."
-The investigation regarding the wrong medication given to FC #5 did not substantiate any staff although FS #7 and FS #8 resigned.
-Was not aware Staff #5 had access to the nurses' station.

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

Review on 1/26/24 of the 1st Plan of Protection dated 1/26/24 and signed by the DOO revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?

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V 118	Continued From page 29 Immediate Actions Taken: - Updated and implemented pharmacy delivery procedure on 1/5/2024. - Reviewed and attested to updated policy and procedure by all FBC (facility based crisis) staff on 1/12/2024. - Installed visual 5 rights of medication administration guides at all medication administration stations on 1/15/2024. - Developed, implemented, and completed electronic inventory and compliance audit form on 1/17/2024. - Update to and implementation of new daily narcotic count form: Initial implementation of new form on 1/19/2024. - Continue to conduct regular narcotic counts and audits to ensure accuracy and security at each shift change, to be signed and dated by both departing and arriving staff. - Update Security Measures and Badge Review: Review completed on 1/25/2024. - Conduct periodic reviews of security measures and badge assignments for accuracy and compliance by the director of service or designee, at least monthly. - Review of Medication Administration and Incident Reporting Policies: Immediate review initiated 1/26/2024 via email to all staff. - Demonstration of understanding by all FBC staff through an incident report test form by 2/2/2024. - Conduct periodic reviews of policies and procedures related to medication administration and incident reporting at least monthly by Quality Assurance team. Next quarterly meeting is scheduled for 1/29/2024. - All leadership review of medication administration quality and compliance scheduled for 1/31/2024. Describe your plans to make sure the above	V 118		

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V 118	Continued From page 30 happens. Plans to Ensure Compliance: - Conduct periodic, at least monthly, reviews of the pharmacy delivery procedure to ensure ongoing compliance. - Provide ongoing staff training on the updated pharmacy delivery procedure. - Maintain the agency internal system for regular policy reviews and updates at least annually by the Quality Assurance committee. - Conduct periodic training sessions for staff to ensure understanding and adherence to updated policies, at least bi-annually. - Regularly assess and reinforce the presence and visibility of medication administration guides. - Include the guides in staff training programs and orientations. - Regularly conduct electronic audits and inventories to monitor compliance, at least monthly. - Establish a schedule for ongoing reviews of the electronic inventory and compliance audit form. Ongoing Compliance Monitoring: - Dedicate a portion of each quarterly quality assurance meeting to the live conduction of training and medication administration audit. - Provide continuous staff training and education on medication administration, policies, and procedures. Documentation: - Maintain detailed records of all policy updates, training sessions, and compliance audits. - Periodically review and update documentation procedures to meet regulatory standards. - This plan aims to not only address the identified violations but also to establish a comprehensive system for ongoing compliance and quality	V 118		

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V 118	Continued From page 31 assurance within the facility. Regular reviews, training, and audits will contribute to maintaining a safe and secure environment for consumers." Review on 1/26/24 of an addendum to the Plan of Protection and signed by the DOO revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Immediate Actions Taken: - ... by ACS (licensee) Director of Enhanced Services. - ... by ACS Director of Enhanced Services. - ... by ACS Director of Enhanced Services. - ... by ACS Director of Operations. - ... by ACS Director of Operations. - ... by Enhanced Service Manager. - ... by ACS Director of Enhanced Services. - ... - ... by ACS Director of Operations. - ...by Enhanced Service Manager. - ACS Quality Assurance and Training Supervisor, or appropriate designee ... - ...by ACS Director of Operations. Plans to Ensure Compliance: - ACS Director of Enhanced Services ... - ACS Director of Enhanced Services ... - ACS Quality Assurance and Training Supervisor, or appropriate designee ... - ACS Quality Assurance and Training Supervisor, or appropriate designee ... - ACS Director of Enhanced Services ... - ACS Quality Assurance and Training Supervisor, or appropriate designee ... - ACS Director of Enhanced Services - ACS Director of Operations ... Ongoing Compliance Monitoring: - ACS Quality Assurance and Training Supervisor, or appropriate designee ... - ACS Director of Enhanced Services ... Documentation:	V 118		

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V 118	Continued From page 32 - ACS Quality Assurance and Training Supervisor, or appropriate designee ... - ACS Director of Operations ... - ..." The facility serves clients with alcohol use disorder, opiate use disorder, methamphetamine use disorder, major depressive disorder, anxiety disorder and post-traumatic stress disorder. Staff did not follow physicians' orders by administering: 8 doses of multivitamins in 3 days rather than daily to Client #1; 2 doses of Flexeril were administered 3 hours apart and 2 doses were administered 4 hours apart rather than every 6 hours to Client #1; for Clients #2, #4 and FC #5 there were 11 blanks on MARs for medications including methadone, lorazepam, buprenorphine, amitriptyline, meloxicam, gabapentin, hydralazine, lisinopril, Seroquel, Metamucil, multivitamin. 4 doses of Adderall 10mg were administered to Client #1 without an order. Staff #5 was expected to work by herself and would be unable to administer medications while working alone leaving clients who were physically detoxing without medication. FC #5 was administered 2 tablets of 8mg Buprenorphine instead of 2 tablets of 325mg Tylenol sending him into precipitate withdrawals and a trip to the emergency department with severe chest pain. The former medical director wrote in an email that this dose of buprenorphine could have led to overdose and death of someone who had not taken narcotics before. There was no documentation of FC #5 receiving a double dose of methadone as reported by FRN #3 and FMD. FC #5 continued his methadone treatment while residing at the facility. Methadone, which was delivered mostly weekly, was not managed through validation of chain of custody documents,	V 118		

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V 118	Continued From page 33 nor through count sheets signed each time medication was administered. Of the 10 weeks of deliveries, only 4 signed verification documents could be presented. 48 doses of 80mg methadone were delivered without any verification. Staff also reported methadone could be found on top of the medication cart rather than locked in the narcotics box. FC #6 also continued methadone treatment while at the facility. Seven doses of 120mg methadone were delivered and verified via chain of custody documentation. However, 2 doses went missing before FC #6 was discharged. While microdosing buprenorphine in order to wean off of methadone, FC #5 was mistakenly continued on methadone along with the higher dose of the buprenorphine. He reported to the FMD he was unable to feel his feet, felt unsteady, felt in a dissociated state, unable to breathe and felt like something was stuck in his throat. FC #5 gave up on the buprenorphine titration and continued on methadone. In addition, there were no signed physician's orders for 2 days of the continuing methadone as the coordinating FMD was relieved of her duties. Lorazepam that expired on 7/20/23, continued to be documented as administer for 15 doses. The facility did nothing to dispose of the expired medications. The same expired lorazepam medication card was missing 1 tablet between 1/1/24 and 1/5/24. No regular monthly inventory of medications took place. Counts of narcotics did not always include 2 staff, had frequent discrepancies with no critical or urgent need to find out why. Narcotics were not being signed out consistently, stored properly, counts indicating tablets were missing as well as a diverted narcotic removed from the back of the card. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23	V 118		

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V 118	Continued From page 34 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on record reviews, interviews and	V 119		

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observation the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 2 of 4 audited clients (#1 and #4). The findings are:

Record review on 1/8/24 for Client #1 revealed:
-Date of admission: 12/28/23
-Diagnoses: alcohol use disorder, opiate use disorder, attention deficit hyperactivity disorder, major depressive disorder, anxiety disorder.
-Physician ordered medication dated 12/28/23 included:
-Lorazepam 1mg (milligram) - alcohol detoxification protocol -1 tab (tablet) 4 times a day for 2 days, 1 tab 3 times a day for one day, 1 tab 2 times a day for one day then 1 tab one time on last day of taper.

Review on 1/9/24 of MAR from 12/28/23-1/9/24 for Client #1 revealed:
-Lorazepam was initialed as administered on 12/28/23 at 5:30pm and 9pm; on 12/29/23 at 8am, 11am, 4pm and 9pm; on 12/30/23 at 10am, 4pm and 9pm; once on 12/31/23 and once on 1/1/24.

Record review on 1/10/24 for Client #4 revealed:
-Date of admission: 1/5/24
-Diagnosis: alcohol use disorder
Physician ordered medication dated 1/5/24 included:
-Lorazepam 1mg- alcohol detoxification protocol-1 tab 4 times a day for 2 days, 1 tab 3 times a day for one day, 1 tab two times a day for one day then 1 tab one time on last day of taper.

Review on 1/10/24 of MAR (medication administration record) from 1/5/24-1/9/24 for Client #4 revealed:
-Lorazepam was initialed as administered

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1/5/24 at 6pm and 10:30pm and on 1/6/24 at 9am and 2pm.

Record review on 1/10/24 of control count sheet for house stock Lorazepam 1mg tablet dispensed on 7/20/22 with expiration date of 7/20/23 but the facility continued to dose for 15 doses of expired meds and there was nothing done to dispose of expired meds.

Observation on 1/10/24 at approximately 12 noon in the control lock box was one Lorazepam medication blister pack card dated 9/30/23 and containing 30 tabs.

Interview on 1/12/24 and 1/24/24 with the local pharmacist revealed:
-"The control sheet label would match the card dispensed."
-"It (lorazepam) will not be as effective after the expiration date but lorazepam is not one that could become toxic after the expiration date."
-"The last Ativan (lorazepam) dispensed was September 2023; 30 tabs."

Interview on 1/10/24 with RN (registered nurse) #1 revealed:
-"I can't keep up with everything."
-The expiration date on the control card was just overlooked.
-It would be the responsibility of a nurse manager (that position had been eliminated) to spot discrepancies (including medication errors) and conduct the administrative tasks while RNs could provide patient care.

Interview on 1/12/24 with the Director of Operations revealed:
-If the medication cart inventory was being conducted monthly as per policy, there would not

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V 119	Continued From page 37 have been any expired medications. "Don't know what happened." This deficiency is cross referenced into 10A NCAC 27G.0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 119		
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 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 reviews and interviews, the facility failed to ensure all medication administration errors were immediately reported a pharmacist or physician affecting 3 of 4 audited current clients (#1, #2, #4) and 1 of 2 audited former clients (FC #5). The findings are: Record review on 1/8/24 for Client #1 revealed: -Date of admission: 12/28/23 -Diagnoses: alcohol abuse, opiate abuse, attention deficit hyperactivity disorder (ADHD), major depressive disorder, anxiety disorder.	V 123		

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-Physician ordered medications included:
-Clonidine 0.1mg (milligrams) (ADHD) - 1 tabs(tablet) in am, 2 tabs in pm ordered 12/28/23
-Multivitamin (supplement) - 1 tab daily ordered 12/28/23.
-Flexeril 10mg (muscle cramps)- 1 tab every 6 hours PRN (as needed) ordered 12/29/23.
-There was no order presented for Adderall 10mg.

Review on 1/9/24 of MARs (medication administration record) from 12/28/23-1/9/24 for Client #1 revealed:
-Clonidine was documented as "missed" 1/1/24 pm dose.
-Multivitamin was initialed as administered on 12/29/23 three doses, 12/30/23 three doses and 12/31/23 two doses. (8 doses)
-Flexeril was initialed as administered on 1/4/24 at 12:30pm, 4:30pm (4 hours apart) and 7:30 (3 hours apart); on 1/6/24 at 9:00am, 1:00pm (4 hours apart), 4:13pm (3 hours apart).
-Adderall 10mg (ADHD) -1 tablet once daily at 11am was initialed as administered 12/29/23, 12/30/23, 1/1/24, 1/3/24. (4 doses)

Record review on 1/8/24 for Client #2 revealed:
-Date of Admission: 12/31/23
-Diagnosis: alcohol use disorder
-Physician ordered medications dated 12/31/23 included:
-Multivitamin (supplement) - 1 tablet daily.

Review on 1/9/24 of MARs from 12/31/23-1/9/24 for Client #2 revealed:
-Multivitamin was not documented as administered on 1/6/24.

Record review on 1/10/24 for Client #4 revealed:
-Date of admission: 1/5/24

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V 123	Continued From page 39 -Diagnosis: alcohol use disorder -Physician ordered medication dated 1/5/24 included: -Lorazepam 1mg (alcohol withdrawal symptoms)- give 4 times daily for 2 full days. Review on 1/10/24 of MAR from 1/5/24-1/9/24 for Client #4 revealed: -Lorazepam was not documented as administered on 1/7/24 at 10pm dose. Record review on 1/8/24 for FC #5 revealed: -Date of admission: 9/21/23 -Date of discharge: 12/29/23 -Diagnoses: alcohol use disorder, opiate use disorder, methamphetamine use disorder, depressive disorder, anxiety disorder, post-traumatic stress disorder, treatment resistant hypertension. -Physician ordered medications included: -Amitriptyline 25mg (depression) - 1 tablet 3 times a day ordered 11/6/23. -Amitriptyline 100mg - 1 tablet at bedtime ordered 11/6/23. -Gabapentin 300mg (pain) - 1 capsule 3 times daily ordered 11/22/23. -Hydralazine 20mg (hypertension) - 1 tablet 3 times a day with meals ordered 10/30/23. -Hydralazine 25mg - 1 tablet 3 times a day with meals ordered 11/13/23. -Hydralazine 50mg- 1 tablet 3 times a day with meals ordered 11/22/23. -Prazosin 5mg (hypertension) - 1 tablet 3 times daily ordered on 11/13/23. -Buprenorphine 8mg (opioid use disorder) - 1 tablet twice daily ordered 12/8/23. -Buprenorphine 8mg - 8mg in AM on 12/17/23 and 12/18/23; 4mg in AM ordered 12/16/23 then discontinue on 12/19/23. -Meloxicam 7.5mg (pain) -1 tablet twice daily	V 123		

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V 123	Continued From page 40 ordered 11/11/23. -Lisinopril 20mg (hypertension) - 1 tablet twice a day at breakfast and at bedtime ordered 10/20/23. -Seroquel 12.5mg (depression) -1 tablet 3 times a day with meals ordered 11/27/23. -Metamucil Powder (fiber supplement) -2 tablespoons twice daily ordered 9/23/23 . -Methadone 80mg (opioid use disorder) 1dose daily ordered on 11/4/23 from 75mg ordered 9/20/23. Review on 1/9/24 of MARs from 11/1/23-12/29/23 for FC #5 revealed: -Amitriptyline 25mg was marked "refused" on 11/15/23 noon dose and marked "missed" on 11/26/23 at 4:30pm dose and 100mg was not documented as administered on 12/2/23. -Gabapentin was marked "missed" 11/26/23 4:30pm dose and was not documented as administered on 12/2/23 pm dose. -Hydralazine 20mg was marked "not available" 11/6/23 at noon and 4:30pm doses. -Hydralazine 25mg was marked "refused" 11/15/23 noon dose. -Hydralazine 50mg was marked "missed" 11/26/23 4:30pm dose, marked "not available" 11/28/23 4:30pm dose and was not documented as administered on 12/2/23 7:30am dose or 12/6/23 4:30pm dose. -Prazosin was marked as "missed" 11/26/23 4:30pm dose. -Buprenorphine was marked "refused" 12/18/23, 12/19/23 and was not documented as administered 12/14/23 pm dose. -Meloxicam was not documented as administered on 12/2/23 pm dose. -Lisinopril was not documented as administered on 12/2/23 pm dose. -Seroquel was not documented as	V 123		

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V 123	Continued From page 41 administered on 12/3/23 7am dose. -Metamucil was not documented as administered on 12/2/23 pm dose. -Methadone was not documented as administered on 12/3/23. Review on 1/9/24 of facility records revealed: -No documented evidence of notification to a physician or pharmacist for missed or refused medications for Client #1 or FC #5. Interview on 1/16/24 with the Registered Nurse (RN) #2 revealed: -In addition to documenting the MAR, she added in her nursing shift notes if a client missed or refused a medication. -Assumed the Nurse Practitioner who saw patients every day also read her notes. -She did not contact the physician or pharmacist if a client missed, refused or was not administered a medication. Interview 1/11/24 and 1/25/24 with the Director of Operations revealed: -"Process for missed medications would be to report immediately to administration and create an incident report which goes to QA (quality assurance) team who reviews, levels, make recommendations and would investigate if level II or III or would have operations do investigation. " -Incident reports regarding medications should have been reported to Former Medical Director or nurse practitioner. There was no documentation if this notification occurred. This deficiency is cross referenced into 10A NCAC 27G.0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 123		

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V 366	Continued From page 42	V 366		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

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by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not

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available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies governing their response to incidents. The findings are:

Review on 1/8/24 of internal incident reports from 11/1/23-1/8/24 revealed:
-On 11/26/23, FC #5 was mistakenly administered two 8mg buprenorphine tablets instead of two 325mg Tylenol tablets which threw him into precipitated withdrawals and required a visit to the emergency department.
-"Nothing was done for the mistake because it was not reported to the nurse that two narcotics were missing and the Subutex card reportedly

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V 366	Continued From page 45 was put behind the Tylenol card ...Level I." -There was no documentation that showed risk cause analysis of the incident, if the facility developed and implemented corrective measures to prevent similar incidents in the future or the assigned staff to be responsible for implementing corrections or preventative measures. Review on 1/9/24 of the North Carolina Incident Response Improvement System (IRIS) from 11/1/23-1/8/24 revealed: -There was no level II or III incident report on or about 11/26/23 submitted by the facility. Interview on 1/10/24 with the Director of Operations revealed: -All internal incidents were kept on a system-wide spread sheet for QA (quality assurance) to review and level, implement necessary changes or corrective actions if needed . -QA identified the incident on 11/26/23 as a level I incident.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall	V 367		

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be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of

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Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to report all Level II incidents to the LME/MCO (Local Management Entity/Managed Care Organization) within 72 hours of becoming

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V 367	Continued From page 48 aware of the incident. The findings are: Review on 1/8/24 of IRIS (Incident Response Improvement System) reports 11/1/23-1/8/24 revealed: -IRIS report dated 11/14/23 regarding possible neglect on 11/10/23 by Staff #6 and FS #7 by drinking while client went into court and then allowing client to drive a facility vehicle back to the facility. Internal investigation did not substantiate. Report was submitted 11/14/23. -IRIS report dated 12/26/23 regarding FC #5 falling, causing a laceration to his head. He was taken by EMS (emergency medical systems) to ED (emergency department) treated and released. Report was submitted 1/2/24. -No IRIS report for Former Client (FC) #5 when staff administered buprenorphine on 11/26/23 mistaking it for Tylenol. FC#5 required emergency medical treatment as a result of the error in medication administration. Interview on 1/10/24 with the Director of Operations revealed: -Process for reporting incidents was for staff to enter all pertinent information on the internal form which is then transferred to a spread sheet for the QA (quality assurance) team to review and determine the level of the incident. If they determine the incident was level II or III, the QA team submit the incident through IRIS.	V 367		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping	V 539		

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

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V 539	Continued From page 49 hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on record reviews, interviews and observation, the facility failed to provide accessible areas for personal privacy affecting 1 of 4 audited clients (#2). The findings are: Record review on 1/8/24 for Client #2 revealed: -Date of admission: 12/31/23 -Diagnosis: alcohol use disorder Observation on 1/8/24 at approximately 11am of client #2's bedroom (also called the observation room) revealed: -There was a camera on the wall over the bedroom door. -The camera was pointed at Client #2's bed. Interview on 1/8/24 with Client #2 revealed: -Had been there 8 days and had been assigned to the same bedroom the entire time. -Didn't care about the camera in the bedroom . Interview on 1/10/24 with Registered Nurse (RN) #1 revealed:	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-068	A. BUILDING: ______ B. WING ______	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 539	Continued From page 50	V 539		

-There were no protocols for a client to use the observation bedroom where the surveillance camera is present.
-Used the observation room for "anyone anytime; fall risks, risk of suicide, transgender or for comfort." It was the only single room without a shared bathroom on the unit.
-"Person (FC #5) assigned to that room a couple weeks ago was angry and tried to cover up the camera."
-RN #2 was the only staff working when Client #2 was admitted and she wanted him close to her to monitor.

Interview on 1/16/24 with RN #2 revealed:
-Used the observation room for a behavioral issue, fall risk, risk of self harm or suicidal.
-FC #5 fell out of bed, cut his head and went to the emergency room. "I put him in that upon his return. He wasn't happy and tried to cover up the camera."

Interview on 1/10/24 with the Director of Operation s revealed:
-The nurse practitioner or the intake nurse could make the decision to put someone in the observation room based on symptomology but there was no guidance to follow. Cameras were monitored on screens in nurses ' station and in the CMHA (community mental health assistant) administrative office.
-The camera had been there for years and never cited.