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V 000	INITIAL COMMENTS A limited follow up survey for the Type A1 was completed on 5/16/24. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Requirements (V118, V119, and V123) and 10A NCAC 27G .0201 Governing Body Policies (V105) were reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .0209 Medication Requirements (V119). 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 .4400 Substance Abuse Intensive Outpatient Program has a current census of 1 and the .5000 Facility Based Crisis Program for Individuals of all Disability Groups has a current census of 5. The survey sample consisted of audits of 3 current clients in the .5000 Facility Based Crisis Services for Individuals of all Disability Groups.	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	V 105		

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V 105	Continued From page 1 (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 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;	V 105		

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(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;

This Rule is not met as evidenced by:
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. The findings are:

Review on 4/18/24 of the facility's Medication Storage and Disposal policy issued 5/17/23 with last revision dated 12/21/23 revealed:
-"...Monthly Medication Check
-Monthly medication checks shall be conducted by the Nurse Manager or their designee to ensure:
-all medications are within their expiry dates;
-all inactive client medications have been disposed of within 30 days.
-All monthly medication checks must be documented on the Medication Check Log in the medication room..."

Review on 4/18/24 of Non-Narcotic Medication

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V 105	Continued From page 3 Inventory Reports for period of 2/18/24 through 4/18/24 revealed: -Monthly medication inventories were not documented in March. Interview on 4/26/24 with the Registered Nurse (RN) #1 revealed: -"[Former RN (FRN) #4] did the count in March (2024) and I signed with her." -Did not know where the March 2024 Non-Narcotic Medication Inventory Report was maintained. Interview on 4/22/24 with the Enhanced Services Manager (ESM) revealed: -Supervised the nurses and was responsible for reviewing the inventory counts. -The night nurses were completing the inventory counts. They would scan the documents into the electronic medical system but there was no documentation for March 2024. -"[RN #1] just did the inventory the other day. I don't know if that March inventory got done. It was just overlooked." Interview on with the Director of Operations revealed: -FRN #4 left employment on 3/26/24 but the responsibility for completing medication inventories should have been reassigned by the ESM. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a failure to correct Type A1 rule violation.	V 105		
V 116	27G .0209 (A) Medication Requirements	V 116		

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V 116	Continued From page 4 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule.	V 116		

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This Rule is not met as evidenced by:
Based on record reviews, interviews and observation, the facility failed to ensure dispensing of medications was restricted to pharmacists, physicians or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 2 of 3 audited current clients (#1, #2). The findings are:

Record review on 4/26/24 for Client #1 revealed:
-Date of admission: 4/14/24.
-Diagnoses: Unspecified Substance Use Disorder, Major Depressive Disorder.
-Date of discharge: 4/23/24.
-Discharge order dated 4/22/24, send #21 (capsules) Keflex (antibiotic) 500 milligrams (mg) take 1 tablet (tab) PO (by mouth) TID (3 times a day) for 7 days.

Record review on 4/26/24 for Client #2 revealed:
-Date of admission: 3/28/24.
-Diagnoses: Major Depressive Disorder, Post-Partum Depression, Generalized Anxiety Disorder, Hypothyroidism.
-Date of first discharge: 4/11/24.
-Discharge orders dated 4/8/24, "provide 7-day supply of Abilify (antipsychotic) and Wellbutrin (antidepressant)."
-Readmission: 4/11/24.
-Date of second discharge: 4/22/24.

Observation on 4/19/24 at approximately 1pm of the medication cart revealed:
-2 small white envelopes approximately 2"x3" with pills inside. On one envelope was handwritten: Wellbutrin 150mg XL (extended release), Client #2's name, dated 4/8/24, directions to take one by mouth every morning at 10am, "Dr." (Doctor) had

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been pre-printed on the envelope but had been marked through and NP (Nurse Practitioner) with the NP's name had been substituted, and the number of pills in the envelope was noted as 7. The unsealed envelope contained 5 pills. On the second envelope was handwritten: Abilify 10mg, Client #2's name, dated 4/8/24, directions to take one by mouth every morning at 10am, "Dr." had been pre-printed on the envelope but had been marked through and NP with the NP's name had been substituted, and the number of pills in the envelope was noted as 7. The unsealed envelope contained 6 1/2 pills.

Interviews on 4/19/24 and 4/26/24 with Client #2 revealed:
-On 4/11/24, "I was discharged and came back. [Staff #3] took me (to a shelter after discharge but the placement fell through). I'm leaving again on Monday (4/22/24)."
-Took both medications herself when she was at the new facility after she was told there were no vacancies.
-Medications were in the backpack she was taking to the new facility.

Interview on 4/23/24 with Staff #3 revealed:
-On the morning of 4/11/24, she transported Client #2 to nearby town's shelter which had previously accepted Client #2. Was given the white medication envelopes by Staff #1 and put the envelopes in a backpack which she gave to Client #2.
-Was not aware of specifically what was in the white envelopes other than medication.

Interview on 4/22/24 with RN #1 revealed:
-Following orders from the NP, she created the 2 white medication envelopes, one for Wellbutrin XL and one for Abilify, each with 7 days of

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V 116	Continued From page 7 medication for Client #2 who was to be discharged on 4/8/24. Client #2's intended new placement fell through, so Client #2 returned to the facility and the white medication envelopes were placed in the side compartment of medication cart for storage. -The client discharge process was, "provider (NP) will write in the orders to give this many days worth of meds (medications) at discharge; the nurse or med tech (technician) would pack white medication envelopes with required number of days and write the med name, dosage, instructions, prescriber and date prepared; staple the envelope. Sometimes the envelopes with instructions are stapled to blister pack...might also send samples from med room." -"Has always been standard practice (for nurses and med techs to package medications)" after the Former Medical Director (FMD) left the facility in December 2023 or January 2024. The FMD used to work at the facilty on site. -"Always had access to the samples closet but never added to inventory...didn't understand how those medications work...were for outpatient and inpatient at no cost...used white envelopes to write instructions...might use a card (blister pack) that had less than 30 (pills)..." Interview on 4/25/24 with the NP revealed: -Had worked at the facility almost 2 years. -All appointments were virtual. He was not on site at the facility. -"If a client is discharged to a facility, they may require the client bring 7 days of medications and scripts (prescriptions). They are all different; may require 14 days (of medications)...If a client is going home, we normally do not send along meds (medications). Never send controls (controlled medications)." -The facility that accepted Client #1 only needed	V 116		

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7 days supply of antibiotic.
-"[FMD] would pull meds from house stock or pull samples for discharging clients ..."
-"I was not aware of the nurse popping house stock into envelopes for discharging client meds."
-"I never worked in a place where I could hand meds out..."

Interviews on 4/25/24 and 5/14/24 with the Director of Operations (DOO) revealed:
-"The medication samples are provided through [pharmaceutical company] for the Patient Assistance Program (PAP) for the outpatient program."
-"Was only aware of discharge medications coming through PAP."
-The facility did not have a permit from the North Carolina Pharmacy Board because they "don't dispense medications."
-"The policy has always been they are not to dispense (medications)."

Review on 4/26/24 of the first Plan of Protection dated 4/26/24 and signed by the DOO revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-On 4/19/2024 a thorough internal review of the events leading to the alleged incident on 4/11/2024 was initated per agency policy, focusing on the medication management and administration procedures required by ACS (Licensee) policy and regulation. On 4/20/2024 immediate personnel actions were taken, including discussions with the involved staff member [CMHA #3 (community mental health assistant)] who subsequently resigned. This discussion helped clarify the breakdown in communication and adherence to protocol that may have occurred.
-On 4/20/2024 a reminder and visual training was

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V 116	Continued From page 9 sent to all FBC (facility base crisis) staff regarding the use of the FBC intranet which houses all pertinant policy and procedure, contact information, compliabnce information, and additional resources specific to their service line. -On 4/22/2024 documented corrective action was approved for CMA (certified medical assistant) and CMHA staff who had been in contact with the medication cart since 4/11/2024. These corrective actions are in the proces of being delivered appropriatly. These actions include specific training and retraining on correct medication handling procedures and adherence to safety protocols. -On 4/23/2024 additional service requirment and documentation training was conducted with RN, CMA, and CMHA staff utilizing the visual training provided on 4/20/2024. Describe your plans to make sure the above happens. -On 4/24/2024 additional verbal review of all medication policies and procedures were prsented to RN, CMA, CMHA, Management, and Clinical Care FBC staff, with each attesting to clear understanding of each. This review included a thorough review of all administration and dispensation polcies and regulations. -On 4/24/2024, staff separation was initiated with [RN #1], following an additional internal review to prevent further regulation violations and address any systemic issues within the team's medication management practices. -On 4/25/2024 ACS leadership met with [pharmaceutical company] representative to further discuss adherence to agency policy and procedure and state regulations, it was confirmed that [pharmaceutical company] and ACS were both in compliance at this time. -To ensure ongoing compliance with the above immediate actions:	V 116		

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V 116	Continued From page 10 Director of Operations can confirm the above actions have been taken on 4/19/2024, 4/20/2024, 4/22/2024, 4/23/2024, 4/24/2024, 4/25/2024, and to present on 4/26/2024. -On 4/26/2024 ACS leadership met with [pharmaceutical company] Director of Operations, Represenative, and Site Cooridnator and agree'ed upon [pharmaceutical company] providing medication admibnistration training to ACS non licensed medication technician staff. [Pharmaceutical company] reprasentative will provide an all staff inservice regarding [pharmaceutical company] patient assistance program services in place on 4/30/2024. Additionally, ACS will continue to conduct monthly medication inventory and will provide DHSR (Division of Health Service Regulation) with these monthly reports by the 2nd Wednesday of each month for a period of time to be determined by DHSR, this will be ensured by the Enhanced Serivce Manager, Director of Enhanced Serivce, and/or approporiate designated medical staff." Review on 5/16/24 of the second Plan of Protection dated 5/15/24 and signed by the DOO revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -On 4/19/2024 a thorough internal review of the events leading to the alleged incident on 4/11/2024 was initiated per agency policy, focusing on the medication management and administration procedures required by ACS (Licensee) policy and regulation. -On 4/20/2024 immediate personnel actions were taken, including discussions with the involved staff member CMHA (community mental health assistant) [Staff #3] who subsequently resigned. This discussion helped clarify the breakdown in	V 116		

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V 116	Continued From page 11 communication and adherence to protocol that may have occurred. -On 4/20/2024 a reminder and visual training was sent to all FBC (facility based crisis) staff regarding the use of the FBC intranet which houses all pertinent policy and procedure, contact information, compliance information, and additional resources specific to their service line. -On 4/22/2024 documented corrective action was approved for CMA (certified medical assistant) and CMHA staff who had been in contact with the medication cart since 4/11/2024. These corrective actions are in te proces of being delivered appropriately. These actions include specific training and retraining on correct medication handling procedures and adherence to safety protocols. -On 4/23/2024 additional service requirment and documentation training was conducted with RN, CMA, and CMHA staff utilizing the visual training provided on 4/20/2024. -On 4/24/2024 additional verbal review of all medication policies and procedures were presented to RN, CMA, CMHA, Management, and Clinical Care FBC staff, with each attesting to clear understanding of each. This review included a thorough review of all administration and dispensation polices and regulations. -On 4/24/2024, staff separation was initiated with [RN #1], following an additional internal review to prevent further regulation violations and address any systemic issues within the team ' s medication management practices. -On 4/25/2024 ACS leadership met with [pharmaceutical company] representative to further discuss adherence to agency policy and procedure and state regulations, it was confirmed that [pharmaceutical company] and ACS were both in compliance at this time. To ensure ongoing compliance with the above	V 116		

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immediate actions:
-Director of Operations can confirm the above actions have been taken on 4/19/2024, 4/20/2024, 4/22/2024, 4/23/2024, 4/24/2024, 4/25/2024, and to present on 4/26/2024.
-On 4/26/2024 ACS leadership met with [pharmaceutical company], Director of Operations, Representative, and Site Coordinator and agreed upon [pharmaceutical company] providing medication administration training to ACS non licensed medication technician staff. [Pharmaceutical company] representative will provide an all staff in service regarding [pharmaceutical company] patient assistance program services in place on 4/30/2024. Additionally, ACS will continue to conduct monthly medication inventory and will provide DHSR (Division of Health Service Regulation) with these monthly reports by the 2nd Wednesday of each month for a period of time to be determined by DHSR, this will be ensured by the Enhanced Services Manager, Director of Enhanced Services, and/or appropriate designated medical staff."

Client #1 and Client #2 were admitted to the facility with unspecified substance use disorder, post partum depression, major depressive disorder and generalized anxiety disorder. Client #2 was first discharged on 4/11/24 with Wellbutrin and Abilify that had been dispensed by RN #1 from facility house stock. The facility did not have a permit with the North Carolina Board of Pharmacy to dispense medications. RNs and/or med techs were responsible for dispensing medications for discharging clients from in-house stock as ordered by NPs during virtual visits. The RNs and med techs were not authorized by law to dispense medications. No authorized prescriber was present to visually check medications being

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 116	Continued From page 13 dispensed to clients. This deficiency constitutes a Type B rule violation which is detrimental to health, safety and welfare of the clients and must be corrected within 45 days.	V 116		
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 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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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 3 audited clients (#1, #2, and #3). 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 (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 1 of 3 audited clients (#2).

Record review on 4/22/24 for Client #1 revealed:
-Date of admission: 4/14/24.
-Diagnoses: Unspecified Substance Use Disorder, Major Depressive Disorder.
-Physician ordered medications included:
-Antacid 200mg (milligram) (indigestion) 10 ml (milliliters) PRN (as needed) between meals and at bedtime ordered 4/12/24.
-Aripiprazole (Abilify) 10mg (mood) 1 tab (tablet) every evening ordered 4/14/24 and discontinued on 4/19/24.
-Subutex (Buprenorphine) 2mg (withdrawal

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V 118	Continued From page 15 symptoms) take 1 SL (sublingual) now, ordered on 4/17/24. -Bupropion (Wellbutrin) XL (extended release) 150mg (depression) 1 tablet daily ordered 4/14/24. -Carvedilol 6.25mg (hypertension) 1 tab twice daily ordered 4/15/24. -Clonidine 0.1mg (detox protocol) 1 tab 4 times daily for 4 full days; 1 tablespoon 3 times a day for 1 full day; 1 tab 2 times a day for 1 full day then 1 tab daily for 1 day then stop ordered 4/12/24. -Clonidine 0.1mg (BP (blood pressure) > 150/90) 1 tab PRN (as needed) max 4, recheck in 1 hour may repeat dose ordered 4/12/24. -Cyclobenzaprine 10mg (muscle cramps) 1 tab every 6 hours PRN ordered 4/12/24. -Depakote 500mg (mood) 1 tab 2 times a day ordered 4/21/24. -Gabapentin 300mg (pain) 1 cap (capsule) 3 times a day ordered 4/12/24 and discontinued 4/18/24. -Gabapentin 400mg (pain) 1 caps 3 times a day ordered 4/18/24. -Glimepiride 4mg (diabetes) 1 tab daily ordered 4/15/24. -Haloperidol 5mg (agitation) 1 tab twice daily PRN ordered 4/19/24. -Haloperidol 10mg One tab twice daily PRN ordered 4/21/24. -Ibuprofen 600mg (pain) 1 tab 4 times daily PRN ordered 4/12/24. -Melatonin 3mg (insomnia) 1-3 tabs PRN ordered 4/12/24. -Metformin 500mg (diabetes)1 tab twice daily ordered 4/15/24. -Ropinirole 0.25mg (restlessness) 1 tab every 4 hours PRN ordered 4/12/24. -Ropinirole 3mg One tab daily at 7pm ordered 4/17/24.	V 118		

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-Seroquel 50mg (mood) 1 tab daily ordered 4/17/24.
-Tylenol 325mg (pain) 2 tabs PRN every 4-6 hours ordered 4/12/24.
-Vistaril 50mg (anxiety) 1 cap 4 times daily PRN ordered 4/12/24.

Review on 4/22/24 of the April 2024 MAR for Client #1 with assistance from RN #2 revealed:
-The new EMAR (electronic medication administration record) system was implemented in January or February and staff did not fully understand how to manage.
-Only able to view one client for the current day.
-Had to scroll to view each medication looking for a small RX symbol indicating need for the medication.
-Scroll back up to the top of the document to make sure of the day it was scheduled.
-Unable to see previous administrations of days before or future medications due.
-Orders were in a different section.
-The Director of Operations (DOO) created and provided 3 "MAR reports" with some of the necessary MAR information in each report.
-No MAR was available for review from the current system for the requested dates.

Review on 4/25/24 of the "EMAR client report-supervisor level" (MAR report #1) from 4/14/24-4/21/24 for Client #1 revealed:
-Documentation of administration under "dosage" was not consistent; either "1" or "2" tablets/capsules was recorded or a number appearing to correlate to the ordered milligrams was documented.
-Antacid 10ml was documented as administered 10 on 4/14/24, 4/19/24. (2 doses)
-Aripiprazole 10mg was documented as administered 10 on 4/14-4/19/24. (6 doses)

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V 118	Continued From page 17 -Buprenorphine 2mg was documented as administered 1 on 4/17/24. (1 dose) -Bupropion 150mg was documented as administered 150 on 4/15-4/21/24. (7 doses) -Carvedilol 6.25mg was documented as administered 1 on 4/16/24-4/21/24. (12 doses) -Clonidine 0.1mg was documented as administered 1 on 4/14/24-4/19/24. (8 doses) -Cyclobenzaprine 10mg was documented as administered 1 on 4/15-4/17/24. (5 doses) -Depakote 500mg was documented as administered 500 on 4/21/24. (2 doses) -Gabapentin 300mg was documented as administered 1 on 4/14- 4/18/24. (8 doses) -Gabapentin 400mg was documented as administered 400 on 4/18- 4/21/24. (11 doses) -Glimepiride 4mg was documented as administered 1 4/16-4/21/24 (6 doses) -Haloperidol 5mg was documented as administered 5 on 4/20/21 and 4/21/24. (3 doses) -Haloperidol 10mg was documented as administered 10 on 4/21/24. (1 dose) -Ibuprofen 600mg was documented as administered 1 on 4/14-4/21/24. (9 doses) -Melatonin 3mg was documented as administered 1 on 4/16-4/21/24. (6 doses) -Metformin 500mg was documented as administered 1 on 4/16-4/21/24. (12 doses) -Ropinirole 0.25mg was documented as administered 1 on 4/15- 4/17/24. (5 doses) -Ropinirole 3mg was documented as administered 3 on 4/17-4/21/24. (5 doses) -Seroquel 50mg was documented as administered 50 on 4/17/24, 4/18/24. (2 doses) -Seroquel 50mg was documented as administered 1 on 4/19/24. (1 dose) -Tylenol was documented as administered 2 on 4/14/24, 4/16- 4/21/24. (9 doses) -Vistaril 50mg was documented as administered 1 on 4/15-4/20/24 (8 doses)	V 118		

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Record review on 4/22/24 for Client #2 revealed:
-Date of admission: 3/28/24.
-Diagnoses: Major Depressive Disorder, Post-Partum Depression, Generalized Anxiety Disorder, Hypothyroidism.
-Physician ordered medications included:
-Synthroid (levothyroxine) 88mcg (micrograms) (thyroid) 1 tab daily ordered 3/28/24.
-Wellbutrin XL 150mg (depression) 1 tab daily ordered 3/29/24.
-Abilify 10mg (mood) 1 tab daily ordered 4/4/24.

Review on 4/22/24 of the 3/28/24-4/22/24 MAR for Client #2 revealed:
-No MAR was available for review.

Review on 4/25/24 of the "line level review report" (MAR report #2) 3/28/24-4/22/24 for Client #2 revealed:
-No time stamp of administration.
-No initials or name of person who administered.
-Documentation of administration under "taken" was not consistent; either "1" or "2" tablets/capsules was recorded or a number appearing to correlate to the ordered milligrams was documented.
-Synthroid 88mcg was not documented as administered or missed on 4/4/24.
-Wellbutrin 150mg was not documented as administered or missed on 4/2/24.
-Wellbutrin 150mg was documented as administered 150 on 3/29/24, 3/30/24, 4/12-4/14/24, 4/19-4/21/24. (8 doses)
-Wellbutrin 150mg was documented as administered 1 on 3/31/24, 4/1/24, 4/3-4/11/24, 4/15-4/18/24, 4/22/24. (16 doses)
-Abilify 10mg was documented as

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administered 1 on 4/3-4/6/24, 4/8-4/19/24, 4/22/24. (17 doses)
-Abilify 10mg was documented as administered 10 on 4/7/24, 4/20/24, 4/21/24. (3 doses)

Review on 4/25/24 of the client "EMAR report" (MAR report #3) 3/28/24-4/22/24 for Client #2 revealed:
-No time stamp of administration.
-No initials or name of person who administered.
-Synthroid 88mcg was documented as administered 1 on 4/4/24.
-Wellbutrin was documented as 'missed' on 4/2/24.
-Synthroid 88mcg was documented as 'missed' on 4/11/24.

Record review on 4/22/24 for Client #3 revealed:
-Date of admission: 4/17/24
-Diagnosis: Amphetamine Use Disorder, Major Depressive Disorder.
-Physician ordered medications included:
-Celexa 20mg (depression) 1 tab daily ordered 4/17/24.

Review on 4/22/24 of MAR from 4/17/24-4/20/24 for Client #3 revealed:
-No MAR was available for review.

Review on 4/25/24 of the "line level review report" (MAR report #2) 4/17/24-4/20/24 for Client #3 revealed:
-No time stamp of administration.
-No initials or name of person who administered.
-Celexa 20mg was documented as administered 1 on 4/17/24, 4/18/24.
-Celexa 20mg was documented as administered 20 on 4/19/24, 4/20/24.

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Attempted interview on 4/19/24 with Client #1 but he declined.

Interview on 4/19/24 with Client #2 revealed:
-Was administered levothyroxine, wellbutrin and abilify. Always received her medications on time. She had not refused any medications. She was not aware of any missed medications.

Interview on 4/19/24 with Client #3 revealed:
-Was there to detox from methamphetamines.
-Was administered ordered medications; celexa and a medication for nightmares. She did not want to take any medications to have "to come off of."

Interview on 4/18/24 with Staff #1 revealed:
-She was 1 of 2 CMHAs (community mental health assistants) trained med techs (medication technician). All other CMHAs were not certified to pass medications.
-"For the last month and a half [RN (registered nurse) #1] was on call all the time (since former RN (FRN) #4 left in March). There was no nurse 3-4 nights a week ... lost a couple of CMHAs because they didn't feel our clients were safe."

Interview on 4/18/24 with Staff #2 revealed:
-Had been a CMHA since 3/13/23.
-"When I first started, I studied the binder and passed the test but never got the hands on part ... I just refused ... I went through the med (medication) training again and now waiting for [RN #1] to observe me passing meds ..."
-"Even in staff meeting, management don't listen to us...went from enotes to [electronic medication documentation system] and shown 30 minutes how to admit people. Recently a guy was discharged ...I don't know what I'm doing ...don't know how to enter (information). [DES (Director

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V 118	Continued From page 21 of Enhanced Services)] doesn't listen or help; offers no support ...we can't help clients if we don't know what to do. They (management) had us do training on ipads for about 40 minutes but can't pull up all the information we need like vitals." Interview on 4/18/24 with Staff #3 revealed: -Started at the facility 1/22/24 as CMHA. -She was not trained to pass medications but was in the training process. Interview on 4/19/24 with Staff #4 revealed: -Began as CMHA the beginning of March 2024. -Had received no medication training at all. -"There has always been a nurse when I worked on weekends." -"None of us knew how to use the [electronic medication documentation system] system ... had no training in charting ....gave us a login but had no clients so nothing really to look up." Interview on 4/22/24 with the Enhanced Services Manager (ESM) revealed: -Was the unit manager responsible for scheduling staff including nurses. -CMHAs had started medication training. Have not had an issue with having untrained staff. -"[electronic medication documentation system] is frustrating. Only given 30 minutes in training ...intensive training should have happened." -"The ipads have glitches" that staff are supposed to use to chart." -"Medication didn't pop up (on the computer screen) to show [Staff #5] that client needed medication ...[Client #2] was not given Synthroid at 7am." -"My staff are leaving because it's not getting better." -"The new system doesn't alert staff to administer	V 118		

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medications any time."

Interview on 4/22/24 and 4/26/24 with RN #1 revealed:
-"The taper schedule in the electronic standing orders was still not correct. The clonidine protocol titration still shows a tablespoon when it's a tablet. I've sent numerous tickets and notified [DES] but nothing had changed."
-"I still can't print a MAR for full administration."
-"[Electronic medication documentation system] auto-populated 4 (administration) times a day when I transcribed TID (three times a day); 4am, 10am, 4pm, 10pm" so it appeared a medication was missed."
-No alarm or notice was provided from the system if a medication was due or past due.
-"Only I was allowed to train the travel nurses but I was never approved to work with [RN #2] but once. At that point she was already so frustrated with [electronic medication documentation system]."
-"Former RN (FRN) #4 and I had to review the MARs. FRN #4 worked 4 overnights and had more time than me."

Interview on 4/19/24 with RN #2 revealed:
-Was a contracted agency RN at the facility since 3/4/24.
-"Not sure what normal is here ...frustrating to feel I'm not safe ...how can I help someone in crisis and let emergency services in the door. It's not safe when detoxing patients are in pain and can be in crisis."
-"At 8am when I arrive, I run through orders before I give any meds (medications) after I get report check orders to the actual med I'm giving; check vitals; narc count with previous nurse; provider calls in AM to give update on admissions and discharges. No way to contact CMHAs

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without walking down the hall ...telemed (telemedication) starting, no phone, walkie or intercom ...scan through group chat but I can't respond to chat ...have to use 2 step authorization to get in again."
-"Its very stressful being a professional with my license and have to stay on my tiptoes every moment."
-"The MAR won't print correctly; doesn't print full doses. Orders are in a different section then have to find specific medication. Have to read over MARs constantly such as order that says a tablespoon of clonidine. Issue is who is transcribing ...has never used med techs ...hard to explain ...it's a hot mess ...system not set up well; too much room for human error and human error is happening."
-"Meds are scheduled all day long ...can't run a report to find out who gets what meds at 8am ...have to scroll through each client, each med to look for a very small RX symbol indicating need for med then scroll back up to make sure of the day its scheduled."
-"Electronic MAR doesn't tell you when something is coming due or when a med has been missed."

Interview on 4/25/24 with the NP (nurse practitioner) revealed:
-Provided virtual services to the facility for almost 2 years.
-The licensee's outpatient program had used electronic medication documentation system for about 1 year. "Using this system for inpatient is a whole new ballgame."
-When he puts in orders, medications are added to the med tab where it shows as an order. Nurse gets the order and transcribes it to the MAR. Has to do that for every medication. There are 15-20 general PRN meds that do not auto populate. "There is too much room for human

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error."

Interview on 4/22/24 and 4/25/24 with the DOO revealed:
-"Have to have clients to practice passing meds ...only had clients since 3/28/24"
-The line level review from client chart (MAR report #2) was not meant to be printed.
-RN #1 had separated from employment as of 4/24/24.
-"Two additional contract RNs started this week." She had requested an additional travel nurse as well as added on call responsibilities to their duties.
-On site NPs will start 5/6/24 and another 5/20/24.
-"[Staff #1] and [Staff #5], both med techs will move to day shift with nurse support."
-"Had entrusted RN to train travel nurses."
-"I provided (system) training with all staff on 2/8/24, 2/14/24, 2/15/24, 2/16/24;
individual training on 2/19/24 and virtual training on 2/20/24 ..."

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 4/26/24 Plan of Protection dated 4/26/24 and signed by the DOO revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
-On 4/19/2024 a thorough internal review of the events leading to the alleged incident on 4/11/2024 was initated per agency policy., focusing on the medication management and administration procedures required by ACS (Licensee) policy and regulation.
-On 4/20/2024 immediate personnel actions were

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	MHL044-068	A. BUILDING: ______ B. WING ______	R 05/16/2024

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V 118	Continued From page 25 taken, including discussions with the involved staff member, [CMHA #3 (community mental health assistant)], who subsequently resigned. This discussion helped clarify the breakdown in communication and adherence to protocol that may have occurred. -On 4/20/2024 a reminder and visual training was sent to all FBC (facility based crisis) staff regarding the use of the FBC intranet which houses all pertinant policy and procedure, contact information, compliabnce information, and additional resources specific to their service line. -On 4/22/2024 documented corrective action was approved for CMA (certified medical assistant) and CMHA staff who had been in contact with the medication cart since 4/11/2024. These corrective actions are in te proces of being delivered appropriatly. These actions include specific training and retraining on correct medication handling procedures and adherence to safety protocols. -On 4/23/2024 additional service requirment and documentation training was conducted with RN, CMA, and CMHA staff utilizing the visual training provided on 4/20/2024. Describe your plans to make sure the above happens. -On 4/24/2024 additional verbal review of all medication policies and procedures were prsented to RN, CMA, CMHA, Management, and Clinical Care FBC staff, with each attesting to clear understanding of each. -On 4/24/2024, staff separation was initiated with [RN #1], following an additional internal review to prevent further regulation violations and address any systemic issues within the team's medication management practices. To ensure ongoing complaince of the above actions taken: -Director of Operations can confirm the above	V 118		

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V 118	Continued From page 26 actions have been taken on 4/19/2024, 4/20/2024, 4/22/2024, 4/23/2024, and 4/24/2024. ACS will establish a routine auditing mechanism that includes unannounced checks on medication management practices to ensure continuous compliance with regulation as well as regular feedback sessions with staff to discuss the effectiveness of implemented policies and any areas needing improvement, the Enhanced Service Manager, Director of Enhanced Services, and/or appropriate designated medical staff will ensure compliance with this action. The agency quality assurance team ensure the review the current incident reporting system to address means to improve the ease of use for all staff and black and white compliance posters will be replaced with in color posters to improve staff awarness of compliance resources." The facility serves clients with unspecified substance use disorder, amphetamine use disorder, major depressive disorder, postpartum depression and generalized anxiety disorder. The facility moved to a new electronic record system built for outpatient services but have tried to adapt it for inpatient services while there were no clients on the unit. Staff expressed having difficulty with ease of system to alert when medication were due or overdue. Staff also expressed lack of training to operate the electronic record system. Medications were administered and recorded inconsistently as 1 or 150 for the same dosage of the same medication. Client #1 with 22 medications, had 9 documented as milligram numbers and 13 medications documented as number of tablets. Gabapentin 300mg was documented with tablet numbers 8 times but Gabapentin 400mg was documented with milligram number 11 times. Ropinirole	V 118		

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V 118	Continued From page 27 0.25mg was documented with tablet numbers 5 times but Ropinirole 3mg was documented with milligram number 5 times. Seroquel 50mg was documented with both tablet number once and milligram number twice. Client #2's Wellbutrin was documented with milligram number 8 times and with tablet number 16 times. Her Abilify was documented with tablet number 17 times and with milligram number 3 times. Synthroid, on report #2 indicated medication was not administered on 4/4/24 but on report #3 it was administered. On 4/11/24, report #2 indicated Synthroid was administered but on report # 3 is was not administered. There was no documentation that the monthly inventory occurred in March. There are 2 NPs both are virtual. There was no established process of notification to the NP for missed or refused medications if staff even knew they had missed a medication. There was a lack of staff training and follow through to ensure accuracy by management. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container;	V 120		

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V 120	Continued From page 28 (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that medications were stored separately for each client and separately for internal and external use affecting 4 of 5 audited current clients (#1, #2, #4, #5) and 1 of 1 former client (FC #6). The findings are: Observation on 4/19/24 at approximately 1pm of second medication drawer, far right section of the facility's medication cart revealed: -1 single pack of Vraylar (antipsychotic) 1.5mg (milligram) packaged by the manufacturer with 7 capsules. Four capsules had been removed. The manufacturer's expiration date was imprinted on the package as 2/2026. There was no pharmacy label indicating whose Vraylar it was. -1 bottle of Delsym 30mg (milligrams) 12 hour cough syrup with pharmacy label for Client #5 dispensed on 4/17/24. Additional Observation on 4/22/24 at approximately 3pm of the facility's medication cart revealed: -Packet of Vraylar and bottle of Delsym as described above.	V 120		

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V 120	Continued From page 29 Additional items stored together included: -Bubble pack of Levothyrozine (thyroid) 88mcg (micrograms) with pharmacy label for Client #2 dispensed on 4/18/24; -3 bubble packs with pharmacy labels for Client #1 rubber banded together of Glimepiride (diabetes) 4mg dispensed 4/15/24, Metformin (diabetes) 500mg dispensed 4/15/24, and Carvedilol (hypertension) 6.25mg dispensed 4/15/24; -2 5.3 ounce cans of antifungal athletes' foot 2% Miconazole (antifungal) with blue sticky notes taped to both cans. One sticky note was blank and one sticky note had Client #4's name handwritten on it. -Bottle of Clindamycin (antibiotic) 300mg with pharmacy label for Client #4 dispensed 4/15/24. Interview on 4/26/24 with the Registered Nurse (RN) #1 revealed: -"The nurse manager was to organize the med (medication) cart...it was a joint effort with me and Former RN #4, but it wasn't part of our job description." -Used to use divider cards or biohazard baggies to separate clients' medications, but was not aware of where those divider cards were currently. -"Vraylar was...in the (med cart) drawer for FC #6." Interview on 4/25/24 with the Director of Operations revealed: -"RNs are responsible for keeping the med cart organized." -"If there is an administrative issue it's [Enhanced Services Manager]. She assigns duties, supervises the nurses and reports to [Director of Enhanced Services]."	V 120		

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V 123	Continued From page 30	V 123		
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 to a pharmacist or physician affecting 1 of 3 clients (#2). The findings are: Record review on 4/22/24 for Client #2 revealed: -Date of admission: 3/28/24. -Diagnoses: Major Depressive Disorder, Post-Partum Depression, Generalized Anxiety Disorder, Hypothyroidism. -Physician ordered medications included: -Wellbutrin (antidepressant) XL (extended release) 150mg (milligrams) 1 tablet (tab) daily ordered 3/29/24. -Synthroid (levothyroxine) (thyroid) 88mcg (micrograms) 1 tab daily ordered 3/28/24. -Omeprazole (indigestion) 20mg 1 capsule (cap) daily ordered 4/17/24. -Mirtazapine (antidepressant) 15mg 1 tab	V 123		

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V 123	Continued From page 31 daily at bedtime ordered 4/16/24. Review on 4/25/24 of the "line level review report" (MAR (medication administration record) report #2) for period 3/28/24-4/22/24 for Client #2 revealed: -There was no time stamp of administration nor staff name/initials of who administered the medications for the following: -Wellbutrin XL was not documented as administered on 4/2/24. -Synthroid was not documented as administered on 4/4/24. -Synthroid was documented as "taken" on 4/11/24. -Omeprazole was documented as "refused" on 4/18/24. -Mirtazapine was documented as "refused" on 4/20/24. Review on 4/25/24 of the "client EMAR (electronic medication administration record) report" (MAR report #3) for period 3/28/24-4/22/24 for Client #2 revealed: -Synthroid was not listed on 4/4/24 on this report. -Synthroid was documented as "missed" on 4/11/24 on this report. Review on 4/22/24 of facility records revealed: -No documented evidence of notification to a physician or pharmacist for missed or refused medications for Client #2 on 4/2/24, 4/4/24, 4/11/24, 4/18/24, 4/20/24. Interview on 4/19/24 with Client #2 revealed: -Was administered Synthroid, Wellbutrin and Abilify. Always received her medications on time. -"I haven't missed any medications that I know of." -"I haven't refused any medications."	V 123		

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V 123	Continued From page 32 -Was discharged and returned on 4/11/24 due to the facility where she was planning to attend next having given away her residential placement. Interview on 4/22/24 with the Enhanced Services Manager (ESM) revealed: -"System is still too new..." It didn't alert staff when medications were due or past due. Interview on 4/23/24 with the Director of Operations revealed: -"Identified the issues with Wellbutrin for [Client #2] (on 4/2/24). [RN #2] was administering from the client chart not the inpatient module which is the live record." -"[Staff #1] changed the reoccurrence pattern for Synthroid in the EMAR on 4/4/24 so there was no evidence of administration or reporting for documentation error for missed medication." -"On 4/11/24, Synthroid was documented at 11:03am that it was administered at 7:03am. Didn't administer from inpatient module and system caught that it was missed." -"On 4/18/24, the Omeprazole was clicked 'taken' before handing the medication to the client who refused. Documented 'taken' at 9:25am and 'refused' 9:38am." -"System was built to indicate when there is an error. Staff are trained to follow the work flow ... [electronic medication documentation system] is complicated." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a failure to correct Type A1 rule violation.	V 123		