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 _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 11/5/24. The complaint was unsubstantiated (intake #NC00217212). 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 Service for Individuals of all Disability Groups. This facility is licensed for 16 and currently has a census of 3. The .4400 Substance Abuse Intensive Outpatient Program has a current census of 0 and the .5000 Facility Based Crisis Program for Individuals of all Disability Groups has a current census of 3. The survey sample consisted of audits of 3 current clients in the .5000 Facility Based Crisis Service for Individuals of all Disability Groups. 27G .0207 Emergency Plans and Supplies	V 000	RECEIVED DEC 10 2024 DHSR-MH Licensure Sect	
V 114	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans 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	V 114	V 114-The facility acknowledges the identified deficiency and has taken corrective actions to address the issue. The following steps have been implemented to ensure compliance moving forward: 1. **Corrective Action:** ○ On December 3, 2024, the fire and disaster drills were conducted. 2. **Training and Policy Clarification:** ○ The point person for all drills has been updated to the Director of Operations. The Director has been informed of the requirement to conduct both fire and disaster drills quarterly for each shift.	11/22/24

Teran Reese, RN, MSN, MBA, CJCP
Director of Operations 12/6/24

PRINTED: 11/07/2024
FORM APPROVED
Division of Health Service Regulation

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V 114	Continued From page 1 simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Review on 11/5/24 of fire and disaster drills for January-September 2024 revealed: -1st quarter (January - March) - no fire and disaster drills conducted. -2nd quarter (April - June) - no fire drill 2nd shift and no disaster drills conducted. -3rd quarter (July - September) - no 2nd shift fire drill and no disaster drills conducted. Interview on 11/5/24 with the Interim Director of Operations revealed: -the facility ran 12-hour shifts (7:00 a.m. -7:00 p.m. and 7:00 p.m. - 7:00 a.m.). -no fire or disaster drills were conducted except on 9/26/24 "when we actually evacuated (due to hurricane)." -"It's on me...I was only doing fire drills...have a schedule for the 2 - 12 hours shifts...I will make sure those (fire and disaster drills) are completed moving forward." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	○ The facility policy has been reviewed and clarified to ensure all leadership are aware of these requirements. 3. **Process Improvement:** ○ An annual calendar has been created to display the dates and times of all fire drills and is located in the Director of Operations office. 4. **Ongoing Compliance Monitoring:** ○ The Director of Operations will oversee the emergency drill schedule to ensure adherence to the updated process. We are committed to maintaining full compliance with the rule and have taken measures to prevent recurrence. A follow-up review of these corrective actions will be conducted within 30 days to ensure their effectiveness.	

V 123 V 123	Continued From page 2 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 review and interview, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 1 of 1 former client (FC) #4. The findings are: Review on 11/5/24 of facility incident reports revealed: -FC #4 was administered Lorazepam 1 milligram, as needed, on 9/10/24 and 9/12/24. -"...the reason for the medication being given was reported...as 'anxiety'...The nurse should have completed the CIWA (Clinical Institute Withdrawal Assessment) which would have directed her to administer the Lorazepam. While anxiety is a question in the CIWA it does not negate the necessity of have the CIWA dictate whether to deliver the PRN (as needed)." -the box for the physician or pharmacist notification was not checked to indicate they were notified of the medication error.	V 123 V 123	V 123- The facility acknowledges the identified deficiency related to the tracking and reporting of incident reports. The following steps have been implemented to ensure compliance and improve processes moving forward: 1. **Incident Report Process Update:** 11/15/24 ○ The Incident Report process is fully electronic and conducted through a Google Form. This ensures accurate and timely documentation of incidents. ○ All staff that administer medications have been educated that ALL errors and drug interactions must be documented in the client's record. This includes the client's refusal of a drug. ○ A refresher training will occur in December 2024 2. **Enhanced Tracking and Review:** 12/2/24 ○ All Incident Reports are now automatically pulled into DOMO, the ACS analytic system, to monitor for trends that may require in-depth review and proactive intervention. ○ The updated Incident Report form includes required fields to document per regulation: i.e. the provider notified, the drug administered and reaction, what was communicated to the provider, and the provider response. 3. **Improved Notification Process:** 11/4/24 ○ Incident Reports are now automatically sent to the inboxes of all leadership for the ARU, the Director of Operations at ACS, the Group Vice President of Operations, the head of Business Operations, and the Quality Manager. This ensures that all relevant ACS and corporate leadership are informed promptly. 4. **Regular Oversight:** 11/18/24 ○ Medication errors documented in incident reports will now be formally reviewed with the ACS

V 123	Continued From page 3 Interview on 11/5/24 with the Nurse Practioner (NP) revealed: -the NP on duty or on-call should be notified of medication errors. -he would assess the client and determine if any follow up was needed. -he usually documented medication error notifications he received and would check his notes. -could not determine if he was notified of FC #4's medication error or not. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 123	Medical Director during the dedicated monthly meeting focused on the ARU. This ensures structured oversight and continuous improvement in medication safety practices.	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based,	V 536		

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V 536	Continued From page 4 include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain	V 536		

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V 536	Continued From page 5 documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive	V 536		

V 536	Continued From page 6 interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audited staff (Staff #1, Registered Nurse (RN) and the Director) received initial training in alternatives to restrictive interventions (RI) prior to providing services. The findings are: Review on 11/4/24 of Staff #1's employee file revealed: -date of hire 8/26/24. -9/25/24 completed approved training in alternatives to RI.	V536	The facility acknowledges the deficiency and has implemented corrective measures to ensure compliance with the regulatory requirements. Crisis Prevention Intervention (CPI) continues to be the training curriculum utilized to meet the requirements for alternatives to restrictive interventions (RI). However, the previous training plan allowed ARU staff an established period to complete CPI training upon hire (30 days), which did not align with regulatory requirements. To address this, the training plan was updated on 11/20/24 to require that ARU staff complete CPI training BEFORE interacting with residents on the ARU floor. This represents a shift in the initial training process, and the facility's orientation program is currently being revised to reflect this requirement.	11/27/24

V 536	Continued From page 7 Review on 11/4/24 of the RN's employee file revealed: -date of hire 10/21/24. -no initial training in alternatives to RI. Review on 11/4/24 of the Director's employee file revealed: -date of hire 10/21/24. -no initial training in alternatives to RI. Interview on 11/5/24 with Staff #1 revealed: -worked 1st shift at the facility for "about 2 months." -completed an "on-line portion" on alternatives to RI prior to working a shift. -the "in-person" training on alternatives to RI was within the "first few weeks" of working. Interview on 11/4/24 with the Director revealed: -had not completed the training on alternatives to RI.	V 536	Recognizing the need for improved training capacity, the facility is increasing the number of certified CPI trainers within ACS from 2 to 4. The additional trainers will include the ARU Director and the BHUC Program Manager. With two trainers based at the facility, the facility will be better positioned to provide timely training during each orientation process, ensuring all new hires meet the training requirements before beginning their duties. The facility is committed to maintaining compliance and ensuring all staff are adequately prepared to provide safe, effective services. *Please note that while staff that work on the ARU will be in compliance, the addition of the 2 CPI trainers to increase our bandwidth to 4 will occur at the next available CPI train the trainer event through the CPI Institute.	1/4/24