Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-384	A. BUILDING: _____ B. WING _____	R 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY BENSON HOUSE	450 MONFORD AVENUE ASHEVILLE, NC 28801

(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 and follow up survey was completed on 12/6/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children. This facility is licensed for 12 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118	RECEIVED DEC 30 2024 DHSR-MH Licensure Seat	

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V 118	Continued From page 1 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 and interviews, the facility failed to ensure medications were administered on the written order of a physician affecting 1 of 3 audited clients (#2) and failed to ensure staff who administered client medications were trained by a legally qualified and privileged person who could prepare and administer medications affecting 3 of 3 staff (Staff #1, Staff #2 and Program Manager/Qualified Professional (PM/QP)). The findings are: Review on 12/3/24 of Client #2's record revealed: -Date of Admission: 2/20/24. -Diagnoses: Opioid Use Disorder, Sedative Use Disorder, Amphetamine Use Disorder, Bipolar Disorder, Post Traumatic Stress Disorder. -Physician ordered medications dated 2/22/24 included: -Ibuprofen 200mg (milligram) (pain) 2 tablets every 6 hours PRN (as needed) not to exceed 6 tab (tablets) in 24 hour period. -Acetaminophen 325mg (pain) take 2 tablets every 6 hours PRN not to exceed 10 tabs in 24 hours. Review on 12/5/24 of Client #2's MARs for period 9/1/24-12/3/24 revealed:	V 118	A Nurse at RHA held an in service training was held with all current staff members at Mary Benson House (MBH) on 12/17/2024 and 12/19/2024 to provide training regarding the competencies of Medication Management. The residents of MBH self-administer their own medications and the staff members oversee the medication monitoring. Training included that the MAR would indicate if a resident was not at the facility on a particular day (on a day pass, overnight, in the hospital, etc.); this would be identified by documentation on the MAR. Additionally, training included information regarding outreaching the pharmacy/ physician for accurate medication orders. Monitoring of this process will be completed through Service Record Review Process. (Attachment A) Moving forward, all new staff members will have a two part training to ensure this training is completed. The "Your Role in the Medication Process" will be followed by an In Service with an RHA Nurse called "Rights of Medication" which will be tracked in RHA's Learning Management System. The in service for the December 2024 and future trainings will be uploaded to the Learning Management System for tracking. (Attachment B)	12/23/2024 12/23/2024

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V 118	Continued From page 2 -Ibuprofen was documented as 3 tablets were administered at one administration time on 9/4/25, 9/5/24 (two times), 9/6/24 (three times), 9/8/24 (two times), 9/10/24 (three times), 9/11/24 (two times), 10/30/24 (two times), 11/29/24 (two times), 11/30/24 (three times). Additionally, ibuprofen was documented as administered a total of 12 tablets on 9/7/24, 14 total tablets on 9/8/24, 10 total tabs 9/9/24, 11 total tablets 9/10/24, 7 total tablets 9/11/24, 8 total tablets 9/12/24, 9 total tablets 10/31/24, 7 total tablets 11/1/24 and 11 total tablets on 11/30/24. -Acetaminophen was documented as administered 3 tablets at one administration time on 9/6/24, 9/10/24 (three times), 9/11/24, 11/30/24. Review on 12/6/24 of Staff #1's record revealed: -Date of hire: 3/4/24 -Training transcript included "Your role in the medication process" online training on 3/11/24. Review on 12/6/24 of Staff #2's record revealed: -Date of hire: 9/3/24 -Training transcript included "Your role in the medication process" online training on 9/16/24. Review on 12/6/24 of PM/QP's record revealed: -Date of hire: 1/30/17 -Training transcript included "Your role in the medication process" online training on 12/11/23. Interview on 12/3/24 with Client #2 revealed: -Had oral surgery early September ..."all upper teeth were removed and 2 on the bottom ..." -"Had papers (instructions from the dentist) telling me how many Tylenol (acetaminophen) and ibuprofen I could take. I don't think I took more than I was supposed to...nothing else I could have for pain except ibuprofen and tylenol ...went	V 118		

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V 118	Continued From page 3 back and forth between the two ..." -"I was an IV (intravenous) user and they couldn't give me anything for pain ..." Interview on 12/6/24 with the contracted pharmacist revealed: -It was typical for both ibuprofen and acetaminophen to be taken together. -The daily maximum of ibuprofen was 2400mg and for acetaminophen was 4000mg. -"Short term doses exceeding these limits was not concerning although not recommended. Long term dosing at this level would not be sustainable." Toxicity/overdose level for acetaminophen was 12,000mg and 30 grams form ibuprofen. Possible effects could be cardiovascular events, GI (gastrointestinal) bleeds, kidney/liver damage. Interview on 12/6/24 with Staff #1 revealed: -She was responsible for "all things medical" at the facility. -Client #1 had dental surgery on 9/4/24 to remove all upper teeth. "They (dentist) left chunks of tooth (in her gums)." -While staff only observed administration, "they should not have allowed [Client #2] to self administer more than ordered." -There were no additional orders from the dentist/oral surgeon. -"I spoke to [licensee's Medical Director] and to [Client #2] regarding taking too many ibuprofen ...." Interview on 12/6/24 with the PM/QP revealed: -Started as new PM on 8/5/24. Worked with agency in other positions though not at the facility. -"I did not have med (medication) administration training with a nurse."	V 118		

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V 118	Continued From page 4 This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or 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 reported immediately to a pharmacist or physician affecting 2 of 3 audited clients (#1, #2). The findings are: Review on 12/3/24 of Client #1's record revealed: -Date of Admission: 8/29/24. -Diagnoses: Major Depressive Disorder, Substance Use Disorder. -Physician ordered medications dated 9/12/24 included: -Westab Plus 27mg (milligram) (prenatal supplement) 1 tablet daily. Review on 12/5/24 of Client #1's medication	V 123	Medication error reports will be completed and submitted by Mary Benson House within the state reporting timelines of a medication error incident. MBH staff will receive in-service training regarding medication error reporting to include a review of the Quick Mar system which includes when a medication error has occurred, what events are considered a medication error, the procedure to notify the pharmacy and/or physician, and how to complete the medication error form. Medication errors will be tracked through RHA's Incident Management System. Monitoring of this process will be completed through the Service Record Review Process and the local QAPI. (Attachment C)	12/23/2024

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V 123	Continued From page 5 administration record (MAR) for period 9/1/24-12/3/24 revealed: -Westab was documented as refused on 10/25/24, 10/26/24, 11/15/24, 11/16/24, 11/18/24, 11/21-12/3/24. (18 doses) Review on 12/3/24 of Client #2's record revealed: -Date of Admission: 2/20/24. -Diagnoses: Opioid Use Disorder, Sedative Use Disorder, Amphetamine Use Disorder, Bipolar Disorder, Post Traumatic Stress Disorder. -Physician ordered medications dated 2/22/24 included: -Naltrexone 50mg (reduce cravings) 1 tablet daily ordered 5/22/24. -Prenatal Tablet 27mg (prenatal supplement) 1 tablet daily for high risk pregnancy ordered 3/27/24. -Quetiapine 100mg (anxiety) 1 tab daily at bedtime ordered 10/29/24. Review on 12/5/24 of Client #2's MAR for period 9/1/24-12/3/24 revealed: -Naltrexone was documented as not administered on 9/22/24, 9/23/24,11/16/24. (3 doses) -Prenatal tab was documented as refused 9/4/24, 9/7/24. (2 doses) -Quetiapine was documented as refused on 11/25/24. (1 dose) Interview on 12/6/24 with Staff #1 revealed: -She was responsible for "all things medical" at the facility. -Had trained staff regarding completing med (medication) error reports and contacting the pharmacy. -"The previous Program Manager did not require med error reports for exceptions like 'physically unable to take' or med not in facility'. Now send med error form to [Licensee's medical Director]."	V 123		

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V 123	Continued From page 6 -Will be in-servicing all staff on completing med error reports.	V 123		

Attachment A

RHA HEALTH SERVICES

In-service Training

Date:	Place Held:	Start Time:
12/17/24	Mary Benson House	8:10Am
		End Time: 9:00Am

Title of Training: How the Med Process looks Medication Administration

Purpose/Outline of Training: Medication Administration

RN reviewed the rights of medication; training on MAR documentation to include documenting if a person is not present at the facility on a day/weekend. RN trained on competencies of staff to oversee monitoring of residents' medications.

Attendance

Printed Name	Signature	Work Location
[redacted]		

[redacted]

Second Instructor's Name | Title/Credentials | Instructor's Signature

RHA HEALTH SERVICES

In-service Training

Date:	Place Held:	Start Time: 0800
12/19/24	Mary Benson House	End Time: 0900

Title of Training: Medication Administration

Purpose/Outline of Training:

RN reviewed the rights of medication; training on MAR documentation to include documenting if a person is not present at the facility on a day/weekend. RN trained on competencies of staff to oversee monitoring of residents' medications.

Attendance

Printed Name	Signature	Work Location
[redacted]		

[redacted]

Second Instructor's Name | Title/Credentials | Instructor's Signature

MENU

Rights of Medication

Attachment B

Rights of Medication

Description	A licensed nurse will train staff on the rights of medication before they can "supervise" the self administration of medication of persons served. This in-service should occur following the completion of the digital course BH and Your Role in the Medication Process.
Content Provider	Internal
Date Added	12/19/2024
Topics	Behavioral Health New Employee Orientation
Language	(empty)
Skill Level	(empty)
Contacts	(empty)
Requires Enrollment	Yes
Skills	(empty)
Content URL	https://www.myworkday.com/rhahealthservices/email-universal/inst/17815$323/rel-task/2997$10951.htmld
Enforce Lesson Order	No

medication.jpg
Uploaded by Erika Harrelson (017707) 3 days ago

Course Number	(empty)
Legacy Course	No

ɔn Schedule Create Reminder

Allowed Assessors [redacted]

Viewing:

Rights of Medication In-Service Sheet	1
Training Activity	Required

Lesson	Rights of Medication In-Service Sheet
Lesson Type	Training Activity
Lesson Order	1
Required	Yes

Lesson Title	Rights of Medication In-Service Sheet
Track Attendance	Yes
Track Grades	Yes
Grading Scheme	Pass/Fail
Training Activity Type	(empty)
Training Details	upload the in-service training sheet as proof of completion

ɔn **Schedule** **Create Reminder**

ɔn Schedule Create Reminder

Attachment C

RHA HEALTH SERVICES

In-service Training

Date:	Place Held:	Start Time:
12/19/2024	Mary Benson House	10:00am
		End Time: 10:30am

Title of Training: Medication Error Reports & Level 1 Incident Reports

Purpose/Outline of Training:

PM reviewed procedures for Level 1 + Med Error incident reports; discussed required time to submit (24 hours); reviewed forms - where located + how to complete; informed team that eMAR system will prompt to complete documentation meaning to complete incident/med error report

Attendance

Printed Name	Signature	Work Location
[redacted]		

Mary Grace Washburn
Instructor's Name (printed)

BA, QP
Title/Credentials

Mary Grace Washburn
Instructor's Signature

Second Instructor's Name

Title/Credentials

Instructor's Signature

RHA
HEALTH SERVICES

In-service Training

Date: 12/19/24	Place Held: Mary Benson House	Start Time: 10:00 am End Time: 10:30am

Title of Training: Urine Drug Screening Policy & Procedure

Purpose/Outline of Training:

PM reviewed 3.08 Drug Screening Policy and Procedure for Substance Use Disorder Treatment Services. from BH Operations Manual. PM reviewed procedures for initiating, monitoring, sealing, storing, and sending lab samples. PM reviewed procedure + disposal for instant/quick test drug screen.

Attendance

Printed Name	Signature	Work Location
[redacted]		

[redacted]

Second Instructor's Name | Title/Credentials | Instructor's Signature