STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-335	A. BUILDING: _____ B. WING _____	R 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HEALTH SOLUTIONS - ASHEVILLE	2 MCDOWELL STREET, UNIT A 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, complaint and follow up survey was completed on 5/17/18. The complaint was substantiated. (intake #NC 00137608). Deficiencies were cited. The census at the time of survey completion was 186. This facility is licensed for the following service category 10A NCAC 27G .3600 Outpatient Opioid Treatment Program.	V 000	DHSR - Mental Health JUN 08 2018 Lic. & Cert. Section	
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 problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105	A few weeks prior to the State Inspection the Asheville CTC the facility started the process of migration to an Electronic Medical Records System. This allows for the immediate signing of all medical orders as they are given. The full utilization of this system will be supervised by the facility's PA, MD, and the Clinic Director going forward. The corporation will also be reviewing the Acadia policy 5.4.2 which states, "it is the responsibility of the nurse to document the CTC Physician's verbal order in the patient's medical record, which the physician will sign within 5 days", at the next corporate policy review meeting on 06/19/2018 to revise its policy for North Carolina to change 5 days to 72 hours, which will bring the Asheville CTC in line with state mandates.	06/19/2018

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V 105	Continued From page 1 (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; This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 105		

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V 105	Continued From page 2 facility failed to implement policies for the adoption of standards that ensure operational and programmatic performance meeting applicable standards of practice effecting 1 of 12 sampled clients (Client #9.) The findings are: Review on 5/17/18 of 10A North Carolina Administrative Code 26 E Section .0300-Prescriptions.0306, Supplying of Methadone in Treatment Programs by RN, Amended Effective August 1, 2002. 10A NCAC 26 E .0306 reads as follows: "The program's medical director shall countersign or sign in the medical record of the program all orders for methadone or other medications approved for use in narcotic addiction treatment by the Food and Drug Administration and under the North Carolina Controlled Substances Act within 72 hours of the initiation of the order." Review on 5/17/18 of the record for Client #9 revealed: Client admitted on 11/29/16 with a diagnosis of Opioid Use Disorder, Bi-Polar Disorder, Anxiety, Depression and Post Traumatic Stress Disorder. Physician Assistant (PA) Verbal Order for Methadone increase dated 3/6/18 was signed by the Physician Assistant dated 3/12/18. PA Verbal Order for Methadone increase dated 4/21/18 was signed in Case Notes by the Physician Assistant and dated 5/4/18. Review of the facility Policy 5.4.2 "Medication Management: Verbal Orders" revealed the following statement: "8. It is the responsibility of the nurse to document the CTC Physician's verbal order in the patient's medical record, which the physician will sign within 5 days."	V 105		

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V 105	Continued From page 3 Interview with the Clinical Supervisor on 5/18/18 revealed that the PA had been off duty the week immediately following the order. The PA signed the order as soon as she returned to duty.	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by:	V 112	On the first day of treatment for a new patient an initial treatment plan will be created in conjunction with the patient. This will be completed and documented within the EMR as noted by the patient's, the counselor's, and the medical provider's signature upon the patient's admission into the program. By day 30 of the patient's treatment their Comprehensive Treatment Plan will be created with the patient's participation within the EMR as noted by the patient's, the counselor's, and the medical provider's signatures on the document. This will continue every 90 days for the patients first year in treatment. Once the patient reaches 1 year in treatment this will move to an annual process or earlier is objectives have been met by the patient. This will be over seen by the facility's Leadership Team, as well as through periodic quality record reviews.	05/17/2018

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V 112	Continued From page 4 Based on interviews and client record reviews, the facility failed to develop and implement a treatment plan within 30 days of admission for 1 of 12 sampled clients (#10), failed to review treatment plans at least annually for 2 of 11 sampled clients (#6 and #11), and failed to secure written consent to the treatment plan by the client for 1 of 11 sampled clients (Client #5). The findings are: Review on 5/17/18 of the client record for Client #10 revealed: Client #10 was admitted on 8/15/17 with a diagnosis of Opioid Use Disorder and Attention Deficient Hyperactivity Disorder (ADHD). The record did not contain a written consent by the client or guardian to the Plan. During the course of interviews with the Clinical Supervisor on 5/17/18, the Clinical Supervisor was asked for assistance in locating and providing documentation of a written Plan for Client #10. She reported the counselor was unable to provide the required documentation. Review on 5/17/18 of the client record for Client #6 revealed: Client #6 was admitted on 2/27/15 and was diagnosed with Opioid Use Disorder. The client record contained a Plan dated 4/13/16 and was signed by the client on 4/14/16. The record did not contain evidence that this Plan had been updated annually as required by rule. During the course of interviews with the Clinical Supervisor on 5/17/18, the Clinical Supervisor was asked for assistance in locating and providing documentation of an updated Plan for Client #6. She reported the counselor was unable to provide the required documentation.	V 112		

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V 112	Continued From page 5 Review on 5/17/18 of the client record for Client #11 revealed: Client #11 was admitted on 4/12/14 and was diagnosed with Opioid Use Disorder. The client record contained a Plan dated 10/21/15. The record did not contain evidence that this Plan had been updated annually as required by rule. During the course of interviews with the Clinical Supervisor on 5/17/18, the Clinical Supervisor was asked for assistance in locating and providing documentation of an updated Plan for Client #11. She reported the counselor was unable to provide the required documentation. Review on 5/17/18 of the client record for Client #5 revealed: Client #11 was admitted on 7/6/11 and was diagnosed with Opioid Use Disorder and ADHD. The client record contained a current Plan dated 8/15/17. The record did not contain evidence that the client had provided written consent to this Plan as required by rule. Consent was to be documented by the client signing their Plan. During the course of interviews with the Clinical Supervisor on 5/17/18, the Clinical Supervisor was asked for assistance in locating and providing documentation of another signed Plan for Client #5. She reported the counselor was unable to provide the required documentation.	V 112		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL	V 131	Please see next page	

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V 131	Continued From page 6 REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to access the North Carolina Health Care Personnel Registry (HCPR) prior to hire in order to ensure each staff member had no substantiated findings of abuse or neglect listed on the HCPR for 1 of 3 sampled staff (Counselor #2). The findings are: Review on 5/16/18 of the Personnel Records for Counselor #2 revealed that she was hired on 4/9/18 and that there was no copy of the hire HCPR being maintained in the facility records. During the course of interviews with the Program Director on 5/16/18 and 5/17/18, the Program Director was asked for assistance in locating and providing documentation of a HCPR check done prior to hiring Counselor #2. The Program Director was unable to provide the required documentation.	V 131	The North Carolina Healthcare Personnel Registry will be checked by either the Clinic Director or the Office Manager prior to any offer being extended to a potential candidate. If the check is clear and the offer is accepted the completed check will be housed in the employee's personnel file.	05/17/2018
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor	V 235	Please see next page	

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V 235	Continued From page 7 to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based upon record review and interview the facility failed to assure that the prescribed ratio of a minimum of one certified staff to each 50 clients was maintained for 2 of 3 counselor caseloads: The findings are: Review on 5/16/18 of the staff caseload documents revealed: Caseload documents for Counselor #1 revealed he had a caseload of 56 clients. This was 6 more clients over the number allowed by rule. Caseload documents for Counselor #2 revealed	V 235	The Asheville CTC had previously offered and filled the open counseling position at the end of March 2018. A week prior to the candidate starting employment the candidate rescinded her acceptance of the position. That position was then reposted and filled in April, another counselor was terminated and the clinic has been searching for her replacement since 05/14/2018. Our corporate recruitment department is working diligently to assist in finding the right candidate and we are confident that this position will be filled prior to 07/16/2018. This is being overseen by the facility's Clinic Director, Clinical Manager, and Regional Director.	07/16/2018

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V 235	Continued From page 8 she had a caseload of 60 clients. This was 10 more clients over the number allowed by rule. Separate interviews on 5/16/18 with Counselor #1 and Counselor #2 revealed: Counselor #1 confirmed the number of Clients on his caseload as 56. Counselor #2 confirmed the number of Clients on her caseload as 60. Interview on 5/17/18 with the Clinical Supervisor confirmed she was aware of the caseloads being over the number allowed by rule. She stated that the facility had had a counselor leave within the last month and that the position was in the hiring process. She stated that filling the vacancy would bring caseload size into compliance.	V 235		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL011-335 (Y1)	A. Building B. Wing (Y2)	5/17/2018 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HEALTH SOLUTIONS - ASHEVILLE	2 MCDOWELL STREET, UNIT A ASHEVILLE, NC 28801

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0536 Reg. # 27E .0107 LSC	Correction Completed 05/17/2018	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 5/17/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/14/2017		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 31, 2018

Nicholas Cawby
Clinic Director
2 McDowell Street, Unit A
Asheville, NC 28801

Re: Annual, Complaint and Follow-up Surveys completed 5/17/18
Mountain Health Solutions-Asheville, 2 McDowell Street, Unit A, Asheville, NC 28801
MHL # 011-335
E-mail Address: Nicholas.Cawby@ctcprograms.com
Complaint Intake #NC 00137608

Dear Mr. Cawby:

Thank you for the cooperation and courtesy extended during the annual, complaint and follow-up surveys completed 5/17/18. The complaint was substantiated.

As a result of the follow up survey, it was determined that the previous deficiency is now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is July 16, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Ms. C. Lisa Niemas-Holmes, Team Leader, at 828-686-0750.

Sincerely,

Richard A Graham MSSA

Richard Graham, MSSA
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Cc: Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO
Smith Worth, SOTA Director
File