STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-117	A. BUILDING: _____ B. WING _____	R 06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HANOVER TREATMENT CENTER	1611 CASTLE HAYNE ROAD, UNIT D WILMINGTON, NC 28404

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on June 20, 2018. The complaint was substantiated (intake # NC00137725). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. The census at the time of the survey was 304.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 1	V 111		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to develop and implement strategies to address the client's presenting problems prior to the establishment and implementation of the treatment plan affecting 1 of 1 deceased clients (DC #10241) audited. The findings are:

Review on 4/26/18 and 4/27/18 of DC #10241's record revealed:
-44 year old male admitted 3/26/18 and discharged 4/4/18 (Deceased on 4/1/18).
-Prior admission from 5/25/16 to 1/9/18. He was discharged due to incarceration.
-Diagnoses included anxiety, depression, PTSD (post traumatic stress syndrome), right leg paralysis, Opioid use Disorder. The physician did not diagnose the client to be in Withdrawal.
-Client reported prescription medications to include Seroquel (antipsychotic), Gabapentin (treats nerve pain and anticonvulsant), and Cymbalta (treats nerve pain and depression).
-North Carolina Controlled Substance Reporting System (CSRS) query dated 3/27/18 documented Carisoprodol (muscle relaxant) had been dispensed for DC #10241 on 3/22/18, and Oxycodone (a narcotic that treats severe pain) on 3/4/18.
-Urine drug screen collected 3/26/18 was negative for all substances tested.
-Induction order dated 3/26/18 for "Methadone 20 mg, increase 5 mg daily if no relief at peak..." DC

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V 111	Continued From page 2 #10241 received a daily 5 mg dose increase from 3/26/18 - 3/31/18 as he reported "no relief at peak." Review on 6/20/18 of DC #10241's Autopsy report dated 4/2/18 documented the cause of death was Methadone and Gabapentin toxicity. Review on 4/26/18 and 4/27/18 of DC #10241's Case Notes revealed: -DC #10241 reported he had been incarcerated for 2 ½ months and was released the prior week. -DC #10241 stated he wanted to be readmitted because he felt he would return to "active use" if he did not get into treatment. Review on 4/26/18 and 4/27/18 of DC #10241's initial problems dated 3/26/18 revealed: -1 problem identified, "Acute Intoxication/Withdrawal." -Risks of relapse was not identified as a presenting problem; no strategies developed for relapse prevention. -Increased risk for overdose and death during the induction phase given his low tolerance to Methadone was not identified as a presenting problem; no strategies developed to educate DC #10241 about his increased risks associated with low tolerance. -Risks of using prescribed/dispensed medications that have the potential to adversely interact with Methadone was not identified as a presenting problem; no strategies to address or educate DC #10241 about his increased risk. Interview on 4/27/18 Counselor #6 stated: -She did the counselor intake process with DC #10241 on 3/26/18. -The counselor intake process included meeting with the client to identify the most severe,	V 111		

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V 111	Continued From page 3 immediate issues at intake. This was good for 30 days. After 30 days, the counselor would sit down with the client and make a better, more thorough treatment plan for the next 90 days. -When she met with DC #10241 she asked him "what are you doing here." He said he thought he would go back to the street and start using again. -DC #10241 had been in jail for 2 ½ months. It had been almost 3 months since he had used so his tolerance was down. -She had reservations about his induction. -"I was shocked that he was going up every day (dosage increases)... He knew what to say to get dose increases... he knew the rules of Methadone and how to get what he wanted." -DC #10241 was not presenting any obvious physical symptoms of withdrawal at intake. -Typically during intake the CSRS was done by the Nursing Services RN (Registered Nurse) Coordinator, then given to the counselor. The Nursing Services RN Coordinator was not there when DC #10241 was admitted, so she probably did not look at the CSRS at intake to see his recent prescriptions. This deficiency is cross referenced into 10A NCAC 27G .3601 Scope (V233) for a Type A1 and must be corrected within 23 days.	V 111		
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	V 118		

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V 118	Continued From page 4 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as prescribed by the physician affecting 1 of 10 audited clients (#11037), and 1 of 5 audited former clients (FC#10979). The findings are: Finding #1: Review on 4/26/18 and 4/27/18 of FC#10979's record revealed: -28 year old male admitted 12/27/17 and discharged 4/24/18. -Admitting diagnosis, Opioid Dependence.	V 118		

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V 118	Continued From page 5 -FC#10979 transferred from another Opioid Treatment Program (OTP) where he had been in treatment for 2½ years and was taking 65 mg of Methadone daily. -Physician documented on admission, "Patient transferring in - requesting dose decrease to 60 mg. Has been gradually decreasing dose for past 2 years - maximum dose was 120 mg - doing well." Physician ordered a daily dose of 60 mg. -1/12/18 dose decreased to 50 mg for "Requests taper." -2/28/18 dose decreased to 45 mg, "Desires MSW (Medically Supervised Withdrawal); may reduce dose by 5 mg every 2 weeks as tolerated until reaching 20 mg. -Order dated 3/13/18, "Patient requesting dose decrease. 'I do not want to be on Methadone' sounds determined to remain clean Decrease dose by 10 mg today, after that 5 mg every week." -Order dated 4/3/18, "Patient has been increased to phase 13. Patient requests to decrease by 5 mg weekly (order already in Methasoft 3/13/18.) Regarding patient take homes, he can have 5 mg decrease for each week." Review on 4/26/18 and 4/27/18 of FC#10979's MAR revealed: -3/13/18 FC #10979 Client's dose was decreased from 45 mg to 35 mg; supplied 6 Methadone 35 mg take home doses. -3/20/18 and 3/27/18 FC #10979 received Methadone 35 mg and supplied 6 Methadone 35 mg take home doses each week. (Based on physician's orders dated 3/13/18 doses should have been decreased by 5 mg each week, for a dose of 30 mg on 3/20/18, then 25 mg on 3/27/18). -4/3/18 FC #10979's dose was decreased to 30 mg and was supplied 6 Methadone 30 mg take	V 118		

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V 118	Continued From page 6 home doses. -4/10/18 FC #10979 received Methadone 30 mg and supplied 13 Methadone 30 mg take home doses. (On site dose should have been decreased by 5 mg to 25 mg and the take home dose starting 4/17/18 should have been decreased to 20 mg.) Review on 4/26/18 and 4/27/18 of FC #10979's case note by the The Nursing Services RN (Registered Nurse) Coordinator, dated 4/24/18 revealed: -FC #10979 stated he had not taken his Methadone in 4 days and did not want to be on any type of narcotic drug. -Client stated he was having restless legs/arms at night when trying to sleep and wanted to know if there was anything over the counter to help with this problem. -Client did not have a primary care physician. An appointment was made with an urgent care clinic to see client after he left the facility. FC #10979 was in agreement to follow up with the clinic. Interviews on 4/26/18 and 4/27/18 the Nursing Services RN Coordinator stated: -FC #10979 came to the clinic 4/24/18, but did not dose. -FC #10979's medication orders had gotten "confused in the shuffle." -On 4/3/18 she was made aware his doses had not been decreased by 5 mg on 3/20/18 and 3/27/18. She entered the order to decrease his dose by 5 mg that day and she put a "flag" in the electronic medical record, (EMR) to alert the nurses to decrease his dose by 5 mg weekly. -She was not aware prior to the survey that FC #10979's dose had not been decreased 5 mg on 4/10/18 and 4/17/18. -FC #10979 stated he had not taken his take	V 118		

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V 118	Continued From page 7 home doses in 4 days. He said he did not want to take Methadone anymore but was still having symptoms to include restlessness and anxiousness. He made it clear he would not be returning to the facility after 4/24/18. -FC #10979 did not have a primary care physician. She (Nursing Services RN Coordinator) called a local urgent care to get him help with the anxiousness. He was seen by the urgent care provider, then saw his counselor to be discharged. -FC #10979 did not return the 4 doses he stated he did not take. -They were suppose to get a client's dose to "0" on a MSW before the client is discharged. Interview on 4/27/18 Counselor #5 stated: -FC #10979 was very frustrated because no one listened to him about wanting to withdraw from Methadone. -FC #10979 told him (the counselor) that he was not coming back to the facility and was going to "self-detox." -He was concerned about the client's risk of relapse. Unable to reach FC #10979 via telephone on 4/27/18 for interview. Finding #2: Review on 4/26/18 of client #11037's record revealed: -31 year old female admitted 4/3/18. -Diagnosis, Opioid Use Disorder. -Order dated 4/3/18 to administer Methadone 10 mg and increase dose by 5 mg daily until she reached a dose of 45 mg, then to be reassessed. Review on 4/26/18 of client #11037's MAR revealed:	V 118		

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V 118	Continued From page 8 -Client #11037's dose was increased by 5 mg daily from 4/4/18 - 4/7/18 to 30 mg. -Client #11037's dose (30 mg) was not increased by 5 mg again until 4/12/18. -Client #11037's dose was increased by 5 mg on 4/12/18 (to 35 mg) and 4/13/18 (to 40 mg). The client's dose was held at 40 mg until 4/23/18. -There was no documentation the physician was contacted for orders to hold the increases. Interview on 4/27/18 the Nursing Services RN Coordinator stated: -Looking at the order for client #11037, there was a discrepancy between the verbal order she received and entered into the EMR, and the order written by the physician in his H&P (history and physical). -During the admission intake process the physician would complete the H&P and escort the client back to her (Nursing Services RN Coordinator). At this point he would give her a verbal intake order that she entered into the EMR. -The physician would enter his intake order into the H&P screen within the EMR. The physician order would not populate the order in the EMR that was followed by the dosing nurses. -There was no process for the physician to review/sign the order she placed in the EMR based on the verbal order. -She did not go back and compare the physician order in the H&P with the verbal order entered into EMR. -Because there was no process to routinely review these orders for consistency, the order discrepancy had not been identified. This deficiency is cross referenced into 10A NCAC 27G .3601 Scope (V233) for a Type A1 and must be corrected within 23 days.	V 118		

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V 233	27G .3601 Outpt. Opiod Tx. - Scope 10A NCAC 27G .3601 SCOPE (a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. (b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual. (c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing doses for a period not to exceed 180 days. (d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide services designed to effect constructive lifestyle changes by using Methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services	V 233		

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V 233	Continued From page 10 affecting 1 of 1 Deceased Client (DC #10241), 2 of 10 current clients (#11037, #1187), and 1 of 5 former clients (FC#10979) audited. The findings are: Cross Reference: 10A NCAC 27G. 0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record review and interviews, the facility failed to develop and implement strategies to address the client's presenting problems prior to the establishment and implementation of the treatment plan affecting 1 of 1 deceased clients (DC #10241). Cross Reference: 10A NCAC 27G. 0209 Medication Requirements (V118). Based on record reviews and interviews, the facility failed to administer medications as prescribed by the physician affecting 1 of 10 audited clients (#11037), and 1 of 5 audited former clients (FC#10979). Finding #1: Review on 4/26/18 and 4/27/18 of DC #10241's record revealed: -44 year old male admitted 3/26/18. (DC #10241 had been a prior client until January 2018 when he was incarcerated.) -Discharged 4/4/18 (Deceased on 4/1/18). -Diagnoses included anxiety, depression, PTSD (post traumatic stress syndrome), right leg paralysis, Opioid use Disorder. The physician did not diagnose the client to be in Withdrawal. -Client reported prescription medications of Inderal (used to treat elevated blood pressure, chest pain and uneven heartbeat)20 mg (milligrams) twice daily, Lisinopril (used to treat elevated blood pressure and heart failure) 40 mg daily, Seroquel (antipsychotic) 150 mg for anxiety, Gabapentin (treats nerve pain and	V 233		

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V 233	Continued From page 11	V 233		

anti-convulsant) 800 mg 3 times daily, Cymbalta (treats nerve pain and depression), and Flomax (treats enlarged prostate).
-North Carolina Controlled Substance Reporting System (CSRS) query dated 3/27/18 revealed Carisoprodol (muscle relaxant) 350 mg, 30 tablets dispensed on 3/22/18, and Oxycodone (a narcotic that is used to treat severe pain) 5 mg, 20 tablets dispensed on 3/4/18.
-Urine drug screen collected 3/26/18 was negative for all substances tested (Opiates, Methadone, Methadone metabolite, Alcohol, Meth/amphetamines, Barbiturates, Benzodiazepines, Cocaine, THC, Oxycodone, and Fentanyl).
-Induction order dated 3/26/18 for Methadone 20 mg, increase 5 mg daily if no relief at peak; if not getting total relief at 50 mg may increase dose by 10 mg every 3 days until 100 mg or total relief is achieved.
-No documentation coordination of care had been initiated with other providers to include the medical providers during incarceration.

Review on 6/20/18 of DC #10241's autopsy report dated 4/2/18 revealed cause of death was Methadone and Gabapentin toxicity.

Review on 4/26/18 and 4/27/18 of DC #10241's Case Notes revealed:
-Client reported he had been incarcerated for 2½ months and was released a week prior to his admission on 3/26/18.
-No documentation client was experiencing withdrawal symptoms.

Review on 4/26/18 and 4/27/18 of DC #10241's dosing history and orders revealed:
-DC #10241's dose was increased by 5 mg daily between 3/27/18 and 3/31/18.

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V 233	Continued From page 12 -The nurses documented the client reported each day he was not getting relief at peak. -No documentation of other symptoms reported or observed. -No documentation the physician was notified of the onset of withdrawal symptoms not present on admission. Finding #2 Review on 4/26/18 of client #11037's record revealed: -31 year old female admitted 4/3/18. -Diagnosis, Opioid Use Disorder. -Client had been a patient at a local office based Suboxone clinic from 2/9/18 - 3/21/18. -Client #11037 reported during her intake assessment that she had prescriptions for Zyrtec, Flonase, and Maxalt. -Client #11037's CSRS query dated 4/3/18 listed Clonazepam 1mg, 60 tablets dispensed on 1/8/18 and 12/4/17 (ordered by a local physician); and, between 2/2/18 and 3/15/18 medications prescribed by the Suboxone clinic were listed (Zubsolv, Suboxone, and Buprenorphin-Naloxon). -No documentation coordination of care had been initiated with other providers. Finding #3: Review on 4/26/18 and 4/27/18 of client #1187's record revealed: -48 year old female admitted 11/8/17. -Diagnoses included Opioid Dependence and Opioid Withdrawal. -Client #1187's most recent CSRS query dated 11/8/17 listed Zolpidem tartrate 10 mg, 30 tabs dispensed monthly from 5/3/17 - 10/23/17 (ordered by a local physician). -No documentation coordination of care had been initiated with other providers.	V 233		

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V 233	Continued From page 13 Interview on 4/27/18 Counselor #5 stated: -He was the counselor for clients #1187 and #11037. -He had not initiated a coordination of care for these clients. Interview on 4/27/18 Counselor #6 stated: -She did the counselor admission process with DC #10241. -Typically the CSRS was done during intake by the Nursing Services RN (Registered Nurse) Coordinator, then it would go to the counselor. The Nursing Services RN Coordinator was not there when DC #10241 was admitted, so she probably did not look at the CSRS at intake to see if controlled substances had been dispensed for the client. -DC #10241 was not presenting any obvious physical symptoms of withdrawal at intake. -She had not sent the coordination of care forms to DC #10241's other providers. Interviews on 4/25/18 and 4/26/18 the Nursing Services RN Coordinator stated: -She was on a leave of absence when DC #10241 was admitted. -DC #10241 was at risk for overdose because of his lack of tolerance from being substance free prior to his admission and having his Methadone dose increased daily after his admission on 3/26/18. -The nurses made their assessments based on what they were told by the patient and their visual assessment to decide if the induction order increases are made. -She expected the nurses to ask more questions when a client reported "no relief at peak" and document the client's responses. This had not been done when DC #10241 had his doses increased.	V 233		

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V 233	Continued From page 14 Interview on 4/27/18 LPN (Licensed Practical Nurse) #8 stated: -DC #10241 came every day reporting the same withdrawal symptoms. He reported having no relief at peak, restless legs, stomach cramps, and diarrhea. She saw that he came in flushed and sometimes appeared to have sweat. -She had discussed his request for increase with another LPN and the counselor, but did not take it to the doctor. -She had discussed this client with the "higher ups" and was told to go by the doctor's orders. -The orders should have been different for patients like DC #10241. His orders were the same as any induction patient. The nurses knew he had been incarcerated and he was "drug free" and that his orders were the same as other patients. The nurses discussed this but did not feel they could question the order. In the past when they had questioned orders nothing was done and they were made to feel like "that's the order and that's what we are doing." Interview on 4/26/18 the Physician stated: -He had been the physician since January 2018. -If someone was incarcerated, his first question was, "Were they given meds in prison or were they detoxed?" If the person felt they wanted to "go back to the street and start using," or if they had started using, they were a candidate for Methadone treatment. One criteria for Methadone treatment was daily use for a year. "Strictly speaking" they don't meet criteria if they didn't use. One answer was to start them on a low dose and tirate to a negative drug screen and no cravings. -If a client was not in withdrawal, they should be started on lowest dose and possibly increase by 5 mg based on symptoms. They should not have	V 233		

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withdrawal symptoms.
-If a client said they had not used, but wanted to go up on their dose, they should not be increased without seeing the doctor.
-DC #10241 was the first case like this that he could remember.

Interview on 4/27/18 Treatment Services Coordinator stated:
-DC #10241 had dosed daily from 3/26/18 - 3/31/18. He was a "no show" on 4/1/18.
-DC #10241's mother called and said his roommate had found him deceased on 4/1/18.
-DC #10241 received care at the VA (Veteran's Affairs). It was her understanding that medications from the VA did not show on the CSRS.

Review on 6/20/18 of the facility's Plan of Protection, dated 6/20/18, and written by the Regional Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
*All staff will be assigned training modules related to treatment planning, reducing medical errors, and Colonial Management Group's (CMG) (the Licensee) dosing policy on 6/20/18.
*A training has been scheduled with the Director of Clinical and Quality Compliance to train on coordinating care, identifying high risk factors, and treatment planning."
-"Describe you plans to make sure the above happens.
*Staff will be trained by the Director of Clinical and Quality Compliance regarding coordinations of care, identifying high risk factors our patients, and Treatment Planning by July 3rd, 2018.
*All staff will complete the Documenting and Treatment Planning Process training module by June 29th, 2018.

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V 233	Continued From page 16 *A chart audit will be conducted by June 29th, 2018 to ensure compliance with coordinations of care, individualized treatment plans, and adherence to CMG's Medical Protocols." DC #10241's was admitted on 3/26/18 with a diagnosis of Opioid Use Disorder and died on 4/1/18 in his home. The cause of death was Methadone and Gabapentin toxicity. DC #10241 did not exhibit withdrawal symptoms on admission and had a negative drug screen. DC #10241's increased risk of overdose and death during the induction phase due to his low tolerance for Methadone, risk of relapse, and risk of taking other drugs that could potentiate adverse effects of Methadone, were not identified as presenting problems and no strategies were developed. On days 2-5 of induction, DC #10241 reported withdrawal symptoms and "no releif at peak," and his dose was increased 5 mg daily. The physician was never notified the DC #10241 had developed/reported withdrawal symptoms. The failure to report or refer the client to the physician prevented DC #10241 the opportunity to be re-evaluated for issues not present or identified on admission; and, for any issues that may have been identified, have them addressed to prevent complications to include overdose and multi-drug toxicity. DC #10241, client #11037, and client #1187 were admitted with diagnoses of Opioid Dependence, Opioid Use Disorder, and Opioid Use Disorder/Withdrawal respectively. The clients had medications prescribed known to have moderate to major risks when taken with Methadone to include Seroquel, Gabapentin, Cymbalta, Carisoprodol, Oxycodone, Clonazepam, and Zolpidem. There was no coordination of care initiated with the other	V 233		

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V 233	Continued From page 17 prescribers for these clients putting them at risk of adverse drug-drug interactions, or potentiation of life threatening effects, such as respiratory depression, when taken with Methadone. FC #10979's was admitted 12/27/17 with a diagnosis of Opioid Dependence, and client #11037 was admitted 4/3/18 and diagnosed with Opioid Use disorder. FC #10979's MSW order written 3/13/18 was not consistently followed 3/20/18 - 4/24/18 (discharge date) and, Client #11037's induction orders were not followed 4/14/18 - 4/23/18. Client #11037's induction order written by the physician, and the order entered into the dosing system differed and were not reconciled, resulting in nurses holding dose increases without an order. On 4/24/18 FC #10979 reported frustration with the delays in his MSW; and, he therefore had decided to "self-detox," putting him at increased risk for relapse, and overdose, should he relapse. These deficiencies constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An Administrative Penalty of $ 12,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 233		