STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-117	A. BUILDING: DHSR - Mental Health B. WING JUL 24 2018	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 Lic. & Cert. Section

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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	Tag V111: the Division of Health Service Regulation (DHSR) cited New Hanover Treatment Center (NHTC) for failure to develop and implement strategies to address the client's presenting problems prior to the establishment and implementation of the treatment plan. NHTC respectfully disagrees with the survey findings. DHSR indicated that for client #10241, the physician did not diagnose the client to be in withdrawal. In fact, the intake physician documented numerous withdrawal symptoms on the initial History and Physical, including nasal stuffiness/unusually moist eyes, nausea/loose stools, observable tremor, yawning, and increased irritability. The physician also documented the fact that the client demonstrated evidence of tolerance to an opioid as well as current physical dependence to an opioid. (See attached document, "History & Physical," with pertinent portions highlighted.) For this same client, DHSR determined that NHTC did not identify as presenting problems the client's: (a) risk of relapse; (b) increased risk for overdose and death during the induction phase because of the client's low tolerance to Methadone; and (c) risk associated with using prescribed or dispensed medications that have the potential to adversely interact with Methadone. DHSR further found that NHTC did not develop strategies for relapse prevention, strategies related to the client's increased risk of overdose/death associated with low tolerance, or strategies to address or educate the client about his increased risk associated with adverse interactions of other	
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 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	V 111	medications with Methadone. NHTC respectfully disagrees with these findings. On 3/26/18, the nurse documented that client #10241 had received education on the induction process, medication education, and the side effects of over-medication for the client. (See attached Case Note for client #10241). Counselor 6's case note dated 3/26/18 noted that client #10241 reported that he had used Oxycodone in the past week, and that he felt that he would return to active use if he did not get into treatment now. Based on all of the above documentation, the physician determined that this client met the criteria for admission set forth in 42 CFR 8.12(e). North Carolina regulations require that based upon the initial assessment, a client treatment or service plan must be developed within 30 days of the client's admission. That plan must address "strategies." If services are provided before the plan has been developed and implemented, a facility must document strategies to address the client's presenting problem. NHTC routinely develops and implements a treatment plan within the first 30 days of a client's admission. Here, client #10241 was admitted because of his risk of relapse. He was provided appropriate education regarding induction and potential side effects and risk factors upon admission. This education was provided as a strategy to address the client's presenting problem. His treatment team at NHTC was in the process of developing his treatment plan. Had this client been in treatment longer, additional strategies would have been identified on the client's treatment plan and	

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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	addressed with the client focusing on relapse prevention and high risk factors. A history of prescribed substances for this client was reviewed in the Controlled Substance Reporting System (CSRS) database on 3/27/18. The results were signed by the physician, verifying his review of the prescriptions listed. Although NHTC disagrees with DHSR's findings, it takes very seriously its obligations to provide appropriate care and services to its clients in compliance with best practices, as well as applicable laws and regulations. In response to the concerns cited by DHSR, counseling staff received training on 7/12/2018 on the facility's process change for identifying high-risk factors, strategies to address these high-risk factors, and the need to identify and document such strategies when services are first provided, whether or not a treatment/service plan has been completed. Such training will be provided to all new employees of NHTC upon hire.	

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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	Tag V118: DHSR cited NHTC for failing to administer medications as prescribed by the physician. Client #10979 – NHTC's internal investigation indicated that the client was to have his dose decreased by 5 mg every week, and that there were 2 weeks when the client's dose should have been—but was not—decreased. During an interview with the facility's Regional Director, the dosing nurse reported that on one of these weeks, the client did not have his dose decreased as ordered because the client asked to not have his dose decreased that week. At the dosing window, the client reported that his dose should be decreasing. When the nurse began to review the dosing orders and asked the client to wait for a moment while she did so, the client said he couldn't wait and asked to remain at the same dose and given that dose. The nurse complied with this request, keeping his dose and take-home doses the same. Client #11037 – NHTC's internal investigation revealed no evidence that a verbal order had been received that was in conflict with a written physician's order for this client. The NSC who	
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	was quoted in DHSR's review is no longer employed and therefore could not be questioned further regarding these statements. However, the facility's Regional Director conducted a Methasoft audit which revealed that neither the NSC nor any other nurse had placed a verbal order in the Methasoft system for this client.	

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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	This audit also revealed that no orders had been deleted from the client's record. Further, the NSC who was interviewed did not place any order into the Methasoft system for this client. The client was properly dosed at 10mg, as ordered by the Medical Director in the intake history and physical. As noted above, NHTC takes its responsibilities to its clients and the concerns raised by the DHSR's findings seriously. Although NHTC respectfully disagrees with the DHSR's findings concerning client #11037, on 7/12/18 and 7/13/18 NHTC retrained nurses on safety in dosing and the importance of verifying and following physician dosing orders in order to assure that physician dosing orders are followed in the future. Additionally, retraining was provided to emphasize the requirement to review each client's dosing history and physician order history before the client receives his or her dose each day. By checking the dosing history and physician order history before doses are administered, nurses will ensure that all physician orders are followed. Nurses also were retrained on the importance of and process for verifying verbal orders and entering such orders promptly into the Methasoft system. Going forward, nursing staff will review each client's history and physical and any written physician order prior to administering the client's first intake dose. An electronic "flagging" system will be implemented as a second method of verifying that nurses are reviewing each client's History and Physical and active orders prior to	

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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	administering a dose. Additionally, nurses were trained on the importance of vocalizing any concerns related to client safety issues, including but not limited to dosing orders. The nurses also were trained on obtaining clarification from the physician anytime a question arises regarding an order. After consultation with the physician, if there are still concerns, nurses have been trained to report those concerns to the Nursing Services Coordinator or Program Director. If the issue is not resolved after reporting those concerns to the Nursing Services Coordinator or Program Director, then nurses were trained to report them to the Regional Director.	

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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	Tag V233 - DHSR cited NHTC for failing 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. The gravamen of this citation appears to be that NHTC did not document coordination of care initiation with clients' other medical providers. Although a best practice, initiating coordination of care with a client's other medical providers within a given time period is not a specific regulatory requirement, and successful coordination depends on a number of factors, including some outside of a facility's control. Client #10241 – NHTC respectfully disagrees with DHSR's findings concerning client #10241. Contrary to DHSR's findings, as noted previously, the intake physician documented withdrawal symptoms on intake for client #10241 to include: nasal stuffiness/unusually moist eyes, nausea/loose stools, observable tremor, yawning, and increased irritability. Further, he documented the client demonstrated evidence of tolerance to an opioid as well as current physical dependence to an opioid on the initial History and Physical. As the physician documented withdrawal symptoms on admission, as well as evidence of the client's dependence and tolerance, the assertion that the physician was not notified that this client had developed or reported withdrawal symptoms is inapt.	

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(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 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	Client #11037 and Client #1187 – While coordination of care had not been initiated for clients #10241, #11037, and #1187, NHTC respectfully notes that there are no regulations establishing when coordination of care measures should be initiated or completed. Further, the failure to obtain information from other treating practitioners within the first week of treatment would not have likely changed how these clients were treated and likely resulted in no further risk to the client. Nonetheless, recognizing the importance of trying to improve its clients' experiences in treatment, quality of care, and outcomes, NHTC has implemented a variety of processes to assure that the coordination of care is addressed during the intake process, including the following: * Effective as of 7/10/18, the coordination of care process is initiated on intake. CSRS verification is obtained for all clients on the day of intake, and each client is asked to identify what additional medications they are taking that are not included on the CSRS. The process includes requesting that clients sign a release to enable staff to communicate with the prescribing physician and documenting whether or not a client agrees to sign such a release. Although NHTC encourages clients to sign consent forms in order to enable staff to coordinate care with outside prescribing physicians, per 42 CFR Part 2, clients cannot be required to sign these forms, and NHTC cannot deny treatment due to a client's refusal to permit the facility to discuss the client's condition with other prescribing providers.	

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	MHL065-117	A. BUILDING: _____ B. WING _____	R 06/20/2018

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V 233	Continued From page 11 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.	V 233	* Additionally, beginning 7/10/18, the intake documentation checklist form, which includes all required initial and CSRS verification, is to be completed prior to the client's initial dose. * A tracking spreadsheet has been created for coordination of care and CSRS reports. This spreadsheet is to be checked weekly by the Program Director and monthly by the Regional Director to ensure compliance. * Going forward, the Nursing Services Coordinator is to complete a monthly review of the history and physicals and physician written orders to ensure staff are in compliance with all physician orders. Per the Plan of Protection previously submitted, these additional items were completed to address the findings above: * Staff was trained by the Director of Clinical and Quality Compliance regarding Coordination of Care, identifying high risk factors of clients, and Treatment Planning. * Staff completed the Documenting the Treatment Planning Process, Client/Client Safety: Reducing Medical Errors, and the CMG Dosing Policy training modules. * A chart audit was conducted to ensure compliance with Coordination of Care, individualized treatment plans, and adherence to CMG's Medical Protocols.	

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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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V 233	Continued From page 15 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.	V 233		

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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		

NEW SEASON
New Hanover Metro Treatment Center (910) 251-6644

HISTORY & PHYSICAL

Patient ID: 10241

Patient's Name: [redacted] Date: 03/26/2018
Medical Director: Dr. Gargett, MD

Identification Data

Age: 44 Race: Caucasian Sex: Male
Marital Status: Divorced Height: 5 Feet 10 Inches
Weight: 174 lbs. lbs Employment: Disabled
Occupation: _____

This lock icon appears to the left of any locked fields. If this field is incorrect, update it in Methasoft and create a new form.

Transfer Patients

Requesting transfer from: _____
Reason for transfer: _____
Length of time in continuous treatment: (Choos Years (Choos Months
Drug Type: (Choose) Dose Amount: 0 mg
Treatment Modality: Induction Current Phase: (Choose)
Stable at current dose? (Choose)
Comments/Reasons: _____

Previous Treatment

Does the patient report having had prior substance abuse treatment? Yes
If yes, please inform the Program Director for records request.

Programs and Dates

Here until Jan 2018; incarcerated and did not return until now.

Legal Status

☒ Clear ☐ Probation/Parole ☐ Case Pending ☐ Warrant(s)

Family History of Chemical Use Disorder

☐ None ☐ Mother ☒ Father ☐ Sister(s) ☐ Brother(s) ☐ Grandparents ☐ Other
If Other, explain.

Drug Use History

Does the patient report a one-year addiction to opioid drugs? Yes
Opioid use 0 months out of last 12 months.
Opioid use 1 days out of last 30 days.
Hours since last use of opioid: _____ Hours
Average daily cost of current opioid habit (past 30 days): $_____ dollars per day.

Type of Drug Used	Age of Patient During First Use	# of Days Used in Past 30 Days	Frequency
Heroin	24	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Oxycodone	26	1 Day	2
	Routes: (Choose All That Apply) ◉ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Hydrocodone	21	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Morphine	28	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Dilaudid	38	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Methadone	34	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Alcohol	13	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Barbiturates		Never Used	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Benzodiazepines	41	1 Day	2
	Routes: (Choose All That Apply) ◉ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Amphetamines		Never Used	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		

Type of Drug Used	Age of Patient During First Use	# of Days Used in Past 30 Days	Frequency
Cocaine	40	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Marijuana	30	0 Days	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
Tobacco	24	30 Days	40
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
List Other Here		Never Used	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
List Other Here		Never Used	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		
List Other Here		Never Used	
	Routes: (Choose All That Apply) ❒ Orally ❒ Smoking ❒ Intravenously ❒ Subcutaneously (Skin Popping) ❒ Nasal Insufflation (Snorting) ❒ Inhalation of Fumes or Vapors (Huffing)		

Female Patients

LMP: ____________________
Pregnant: (Choose)
# of Deliveries: (Choose)

Birth Control: (Choose)
Breastfeeding: (Choose)
# of Abortions: (Choose)

Sterilization: (Choose)
# of Pregnancies: (Choose)

Comments: ____________________

Medical History

Allergies	Zofran, Compazine
Past Medical History	Anxiety Depression PTSD R leg paralysis
Past Surgical History	cholecystectomy appendectomy R rotator cuff heller myotomy

Medical History (Continued)

Prescription Medications	Inderal 20 mg bid/ Lisinipril 40 mg daily/ Seroquel 150 for anxiety/ Neurontin 800 tid/ Cymbalta/ Flomax
Non-Prescription Medication	Motrin

Clinical Opiate Withdrawal Scale

Resting Pulse Rate
Record Beats Per Minute
Pulse Rate 81-100

Sweating
Measured over past half hour not accounted for by room temperature or patient activity
Patient Denies Chills or Flushing

Restlessness
Observation During Assessment
Able to Sit Still

Pupil Size

Pupils Pinned or Normal for Room Light

Bone or Joint Aches

Patient Denies Discomfort

Runny Nose or Tearing
Not accounted for by cold symptoms or allergies
Nasal Stuffiness Or Unusually Moist Eyes

GI Upset
Over last half hour
Nausea Or Loose Stool

Tremor
Observation of outstretched hands
Slight Tremor Observable

Yawning
Observation during assessment
Yawning Once Or Twice During Assessment

Anxiety or Irritability

Patient Reports Increasing Irritability Or Anxiousness

Gooseflesh Skin

Skin Is Smooth

Review of Systems

List Positive Complaints

Skin	x
HEENT	Severe lower caries ; no upper teeth
Neck	x
Breasts	
Respiratory	x
TB Screen	❒ Night sweats ❒ Fever ❒ Anorexia ❒ Weight loss ❒ Bloody sputum ❒ Not Applicable ❒ Prior Treatment for Tuberculosis ❒ Any previous positive TB test ❒ Persistent cough (longer than two weeks in duration)
Cardiovascular	x
Cardiac Arrhythmia Risk Assessment	❒ Family history of sudden & unexplained deaths ❒ History of Long QT syndrome ❒ QT-prolonging or P450 inhibiting drugs (A-list) ❒ History of heart disease or eating disorder ❒ Recent seizure, exertional chest pain, dyspnea, orthopnea, fainting or near fainting, palpitations ❒ Other ❒ Not Applicable
	x
Gastrointestinal	Achalasia; OK since myotomy
Genitourinary	Stricture; Flomax helpful
Musculoskeletal	Chronic back pain; right leg weak
Nervous	Right sciatica
Endocrine	x
Psychiatric	Depression
Comments	

Physical Examination

Vital Signs	Temp: 98.3 Pulse 86 Respiration: 16 BP: 140 / 98 Pain: 6
Skin & Hair	Within Normal Limits
	If outside, explain.
Head	Within Normal Limits
	If outside, explain.
Ears	Outside Normal Limits
	If outside, explain.
Eyes	Within Normal Limits
	If outside, explain.
Nose	Within Normal Limits
	If outside, explain.
Throat	Outside Normal Limits
	Many caries; no upper teeth
Neck	Within Normal Limits
	If outside, explain.
Heart	Within Normal Limits
	If outside, explain.
Lungs	Within Normal Limits
	If outside, explain.
Abdomen	Within Normal Limits
	If outside, explain.
Back & Extremities	(Choose)
	If outside, explain.Lumbar flexion to 12 inches; weak right ankle dorsiflexion and plantar flexion.
Neurological	Outside Normal Limits
	as above

Mental Status Examination

Affect	Appropriate			
	If Other, explain.			
Mood	Euthymic			
	If other, explain.			
	Is the patient actively suicidal?	No	Delusions present?	No
	Hallucinations present?	No	Impaired intellectual or cognitive?	No
	Impairment of memory?	No	Impaired judgment?	No
	Disoriented to person/place or time?	No		
Process	Counting			
	If Other, explain.			

Is a psychiatric consultation warranted? No

If Yes to any Mental Satus Examination questions, explain here.

New Patient Diagnosis

☒ Opioid Use Disorder: 304.00/F11.20 Moderate/Severe
- ☐ With Specifier: In a controlled environment

☐ Opioid Withdrawal: 292.00/F11.23

Indicates presence of comorbid moderate or severe opioid use disorder.

Does the patient demonstrate *evidence* of tolerance to an opioid?	Yes
Does the patient present with current opioid physical dependence with onset at least one year prior to admission?	Yes
Does the patient present with a history of multiple self-administrations of an opioid on a daily basis?	No
Does the patient meet ASAM Patient Placement Criteria for treatment at this level of care?	Yes

Transfer Patient Diagnosis

☒ Opioid Use Disorder: 304.00/F11.20 Moderate/Severe
- ☐ With Specifier: On maintenance therapy

Does the patient demonstrate *evidence* of tolerance to an opioid?	Yes
Does the patient present with current opioid physical dependence with onset at least one year prior to admission?	Yes
Does the patient present with a history of multiple self-administrations of an opioid on a daily basis?	No
Does the patient meet ASAM Patient Placement Criteria for treatment at this level of care?	Yes

Medical Director's Orders

1. The admission/transfer dose of Methadone will be 20mg.
2. Supplemental Dose Approved: (Choose)
   If a supplemental dose is provided to the patient it must be documented and countersigned by the physician within 72 hours. Licensed medical staff must document signs or symptoms justifying supplemental dosing.

   ☐ Methadone: Patient will be reassessed 3 hours after initial dose by the medical staff and the following supplemental orders will be followed:

   ☐ Buprenorphine: Patient will be reassessed 1 hour after initial dose by the medical staff, and the following supplemental orders will be followed:

3. During the Early Induction period the Medical Director may write specific dosing orders detailing medication increases or decreases until patient expresses relief lasting for 24 hours. Any action taken by licensed medical staff in response to these orders must be countersigned by the Medical Director within 72 hours.
4. Routine initial lab tests.
5. Urine drug screen ***before*** the first opioid agonist dose is administered and randomly thereafter.
6. The patient will be seen for individual or group therapy as indicated by their treatment phase and their needs, or based on state regulations, whichever is more restrictive.
7. Patient advised to follow-up with their primary care physician for any general medical complaints.
8. If patient is pregnant, notify program director.

Medical Director's Additional Orders and Admission Statement

Comments or Additional Orders

Increase dose of methadone by 5 mg daily until total 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

1. **Do not dose any patient who appears to be intoxicated.**
2. In the event of **methadone** patient emesis:
    a. Within **15 minutes** after dose, re-dose the patient at **80%** of daily dose.
    b. Within **16 to 30 minutes** after dose re-dose the patient at **60%** of daily dose.
    c. From **31 to 60 minutes** after dose re-dose at **40%** of daily dose.
    d. After one hour do not re-medicate.
3. In the event of a buprenorphine patient emesis:
    a. Do not re-medicate.
4. **Resumption of dosing for methadone patients:**
    a. If the patient has been absent for three or fewer days then resume dosing at 100% of last dose given in the clinic. At patient request the dose may be lowered after a 1-3 day absence, with a physician's order.
    b. If the patient has been absent between 4-6 days:
        i. Resume dosing at 70% of last dose given in the clinic prior to the absence.
        ii. Based on patient response to the resumption dose, give 100% of original dose on second consecutive and subsequent days.
        iii. If the patient misses the second consecutive day, then follow the order for the number of days missed.

iv. At patient request, or if clinically indicated, the dose may be lowered only with a physician's order.
v. In any case where the resumption dosing order results in a dose that is not a whole number, that dose will be rounded up to the nearest whole number.
vi. In any case where the resumption of dosing order results in a dose that differs from the medication dosing table (CMG Clinical form 149), a new physician order must be obtained. In the case where the order cannot be obtained the same day, continue with the calculated non-formulary dose until a new physician order can be obtained.

c. For patients at a dose of 200 mg or less, if the patient has been absent for 7-14 days then:
i. On the first day back dose at 50% of original dose
ii. On the second consecutive day back, dose at 70% of original dose
iii. On the third and subsequent days, obtain new physician orders for any additional dose increases.
iv. If the patient misses the second consecutive day, follow the order for the number of days missed.
v. At patient request or if clinically indicated, the dose may be lowered only with a physician's order.
vi. In any case where the resumption dosing order results in a dose that is not a whole number, that dose will be rounded up to the nearest whole number.
vii. In any case where the resumption of dosing order results in a dose that differs from the medication dosing table (CMG Clinical form 149), a new physician order must be obtained. In the case where the order cannot be obtained the same day, continue with the calculated non-formulary dose until a new physician order can be obtained.

d. Patients at a dose of 201 mgs or higher, if the patient has been absent for 7-14 days:
i. Obtain new physician's orders prior to medicating.

5. Resumption of dosing for buprenorphine patients:

a. If the patient has been absent for three or fewer days then resume dosing at 100% of last dose. At patient request the dose may be lowered after a 1-3 day absence, with a physician's order.
b. If the patient has been absent four or more days, you will need new dosing orders from the physician.

6. **Revision of Current Patient Take-Home Orders**
    a. If a patient does not return all medication bottles from the current take-home order, then the patient will be daily dosed until the next-scheduled pick-up date unless a new order is obtained from the Medical Director reflecting the updated number of take-home doses.
    b. If a patient cannot pick up all medication bottles associated with their current take-home privilege, this order will allow the patient to pick up a lesser number of bottles. Based on this occurrence this will be documented via the Scheduled Event "Tx. Team Eval" in Methasoft and will be referred to the Treatment Team.

This is to certify that I have reviewed all documented evidence to support a one year history of opioid addiction and objective and other evidence to support current physical opioid dependence, and that based on my reasonable clinical judgment, the applicant fulfills State, Federal, and program requirements for admission to opioid agonist treatment.

Required Signature(s)

Medical Director(electronic signature)

3/26/2018 9:46:44 AM

Date/Time

Nurse(electronic signature)

3/27/2018 5:42:49 AM

Date/Time

Document associated with Patient: 10241
Document Name: 41 History & Physical - Revised March 2018_PT_4307_2018_3_26_8_49_52.pdf
Document Description: 41 History & Physical - Revised March 2018

Case Notes

Date: 7/11/2018
Time: 08:13:58

New Hanover Metro Treatment Center (910) 251-6644
1611 Castle Hayne Rd. Bldg. C
Wilmington, NC 28401 910-251-6644

Patient: 10241 - [redacted] **CID:**

4/4/2018	0 Units	Misc. (Non-Billable)	Individual Note	

Miscellaneous - Patient will be discharged today, as deceased. Staff was informed of death yesterday, when mother called to confirm with staff of his death. Report stated that patient was found dead in is home on 4-1-18, with cause of death unknown at this time.

Rachel B Oldham CSA — *4/4/2018 12:29:18 PM*

Entered By - Rachel Oldham — Date

4/2/2018	0 Units	Absent Patient	Individual Note	

Absent Patient - Attempted to contact patient with no answer and no ability to leave a detailed message. Patient emergency contact was called as well with no answer and no option to leave a voicemail.

Rachel B Oldham CSA — *4/3/2018 6:25:52 AM*

Entered By - Rachel Oldham — Date

3/29/2018	0 Units	Nurse	Individual Note	

Nurse - Patient came to me to reassess TB skin test. Nurse noted a reddened area about 10mm but no wheal noted after palpation to skin. PPD result is negative with mild redness. MD made aware. MH, RN

3/29/2018	0 Units	Nurse	Individual Note	

Nurse - Pt's PPD on LFA administered 3/26/2018 was read, charted, and marked as complete today at 0924am. This note is to record that the induration was 10mm with redness (measured perpendicular to the longitudinal axis). Pt reports history of military service and frequent hospitalizations. Pt reports that induration is tender. Referred to NSC for evaluation before dosing. HK, LPN.

Case Notes

Date: 7/11/2018
Time: 08:13:58

New Hanover Metro Treatment Center (910) 251-6644
1611 Castle Hayne Rd. Bldg. C
Wilmington, NC 28401 910-251-6644

Patient: 10241 - [redacted] **CID:**

3/26/2018	0 Units	Orientation	Individual Note	

Note - Patient appears cooperative and engaged in orientation process. Patient participated in a formal orientation session this date. Patient received education about the treatment center and our association with Colonial Management Group, LP and Colonial Management Group, LP's mission. Patient was informed of our hours of operation and dosing hours, in addition to current costs of treatment.
Patient also was advised of how to file a grievance, treatment options and was given a copy of Patient Handbook.

Reviewed patient rights and responsibilities, program rules and grievance procedures. Patient was provided an overview of medicating instructions and Colonial Management Group, LP's philosophy of addiction and treatment. Discussed the ultimate goals of the treatment center and MMT in general, i.e., harm reduction and improved quality of life.

Informed patient of ethical guidelines, confidentiality regulations and HIPAA. Additionally, discussed health and safety issues and evacuation routes in the event of an emergency. Provided patient information regarding infectious diseases and resources available throughout the community.

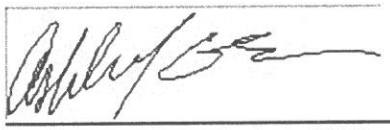
Provided patient information regarding emergency contact in the event that the Program Director is required. Finally, discussed discharge types and protocols, reviewed evacuation procedures, provided the patient a tour of the center, identifying the emergency exits, fire extinguisher locations and accessibility to first aid kits and restrooms.

Ashley Coolman CSAC — *3/26/2018 11:02:38 AM*

Entered By - Ashley Coolman CSAC **Date**

3/26/2018	1 Units	Assessment/Admission	Individual Note	

Assessment/Admission - Patient and counselor completed all necessary paperwork for admission to the clinic. Forms were discussed with patient are as follows: Consent and orientation, transition plan, release (s) for consents to local hospital and EMS. Additional consents are on an as needed basis. Patient is aware of patient rights and responsibilities and attendance requirements. Psych social and treatment plan are initiated.



3/26/2018 11:02:59 AM

Entered By - Ashley Coolman CSAC **Date**

Case Notes

Date: 7/11/2018
Time: 08:13:58

New Hanover Metro Treatment Center (910) 251-6644
1611 Castle Hayne Rd. Bldg. C
Wilmington, NC 28401 910-251-6644

Patient: 10241 - [redacted] **CID:**

3/26/2018	6 Units	DAP Note	Individual Note	07:00 AM-8:30 AM (90 min.)

Data - The patient is a 44 year old male who is presenting for readmission to MMT. The patient was previously discharged due to being incarcerated. The patient reported that he was incarcerated due to missed child support payments for 2.5 months. The patient reported that he was released 1 week ago. **The patient reported that he has used once in the past week. The patient reported that he used oxycodone. The patient reported that he was presenting for readmission because he felt that he would return to active use if he did not get into treatment now.** The patient reported that he has medical complications such as high blood pressure, a paralyzed leg, and herniated discs in his back. The patient reported that he is divorced and live alone in a rented apartment. The patient denied having employment. The patient reported that he "pan handles" for money. The patient reported that "no one else will pay him as much as he makes now". The patient reported that he was previously in the army as a medic. The patient completed all intake paperwork and provided a drug screen.

Assessment - Patient was an active participant in session as evident by open communication and active listening. Patient maintained a positive affect throughout session. Patient appeared alert, oriented, and appropriately dressed for treatment. Patient appears to be in the contemplative stage of change as evident by seeking readmission to treatment.

Plan - The patient will complete psychosocial assessment with counselor next week.

Ashley Coolman CSAC — *3/26/2018 11:57:28 AM*

Counselor - Ashley Coolman CSAC **Date**

3/26/2018	0 Units	Nurse	Individual Note	

Nurse - Patient did re-admit/intake on 3/26/18 with Dr. Gargett, MD, started on 20mg methadone, NCCSRS entered. Patient was educated by Physician on the induction process. **Patient was provided medication education to include side effects of over-medication, and general information about MMT.** Patient also provided informational pamphlet to education family on MMT. ldl, lpn

1/23/2018	0 Units	Misc. (Non-Billable)	Individual Note	

Miscellaneous - Patient got held in contempt of court and was in jail from January 7-20th. ... Patient has not returned to clinic but does not appear to be in jail at this time either.

Robert Martin — *1/23/2018 11:52:08 AM*

Entered By - Robert Martin **Date**

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

DHSR - Mental Health

JUL 24 2018

Lic. & Cert. Section

July 6, 2018

Angela Heaviland, Regional Director
Metro Treatment of NC dba New Hanover Treatment Ctr.
2500 Maitland Center Parkway, Ste 250
Maitland, FL 32751

Re: Complaint and Follow up Survey Completed June 20, 2018
New Hanover Treatment Center, 1611 castle Hayne Road, Unit D4, Wilmington, NC 28401
MHL# 065-117
E-mail Address: angela.heaviland@cmglp.com
(Intake # NC00137725)

Dear Ms. Heaviland:

Thank you for the cooperation and courtesy extended during the complaint and follow up survey completed June 20, 2018. The complaint was substantiated

As a result of the follow up survey, it was determined that all of the deficiencies are 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

- Type A1 rule violation is cited for 10A NCAC 27G .3601 Scope (V233) with cross referenced violations in 10A NCAC 27G .0205 Assessment and Treatment/habilitation or Service Plan (V111), and 10A NCAC 27G .0209 Medication Requirements (V118).

Time Frames for Compliance

- Type A1 violation and all cross referenced citations must be ***corrected*** within 23 days from the exit date of the survey, which is July 13, 2018. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Metro Treatment of NC dba New Hanover Treatment Ctr. for each day the deficiency remains out of compliance.

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 please call Wendy Boone at 252-568-2744.

Sincerely,

Betty Godwin, RN, MSN
Nurse Consultant
Mental Health Licensure & Certification Section

Connie Anderson
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Beth Phillips, MA ED
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
Smith Worth, SOTA Director
File