STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHARLOTTE TREATMENT CENTER, INC.	3315 WILKINSON BLVD. CHARLOTTE, NC 28208

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 7/30/18. The complaint was substantiated (Intake #NC139860). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment Total Census: 296	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105		

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V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement policies and	V 105		

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V 105	Continued From page 2 procedures for applicable standards of practice. The findings are: Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS V118 Based on records review and interviews, the facility failed to ensure medications were administered as ordered and Nurses demonstrated competency for the population served for 1 of 2 Licensed Nurse Practitioners (LPN#1) affecting 1 of 13 current audited clients (#12). Review on 7/26/18 of a policy and procedure titled "Medical Protocol-Medication Errors" documented the following: -"Medication errors involving our patients are serious and will be treated as such regardless of whether the error involved too much medications or not enough medication;" -"The patient involved in the medication error will be assessed and evaluated by the medical staff and the physician will be informed as expediently as possible;" -"The patient will be recommended to receive further medical evaluation and treatment depending on the severity and context of the medication error. Based on the medical staff/Medical Director's assessment, the Medical Director may order the patient be referred to the emergency room at the nearest hospital;" -"The Program Director will identify staff members who will be responsible to make telephone contact with the patient on an hourly basis to ensure patient well-being. Patients may indicate they don't feel they need or want further evaluation or treatment. Medical staff will continue to attempt patient contact regardless;" -"The medical staff will be required to document each hourly contact attempt and each actual contact made with the patient following each	V 105		

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V 105	Continued From page 3 contact episode." Review on 7/25/18 of the facility incident reports from 5/1/18-7/25/18 revealed an incident report dated 6/24/18 regarding client #12 documenting the following: -client #12 entered dosing window, stated his name and number and LPN#1 clicked his name; -client #12 signed signature pad and was dosed; -client #12's brother (client #13) came up to dose and when entered him into the computer, it said he had already dosed; -determined client #12 received client #13's dose of 170mg instead of his physician's ordered dose of 120mg; -client #12 was called back to the window and informed of wrong dose administered; -client #12 was instructed to remain at clinic to be monitored while the physician was contacted for further instructions; -client #12 refused to stay at clinic and be assessed; -client #12 reported he had been on 180mg in the past and he felt fine; -client #12 was instructed to seek medical attention if he felt drowsiness or oversedation; -client #12 reported he was going home and going to bed as he worked third shift; -LPN#1 informed client #12 she would be following up by phone contacts to check on him; -LPN#1 called client #12 at the end of dosing and client #12 reported he felt fine and had no feelings of euphoria or oversedation; -Nurse Manager (NM) discussed with LPN#1 what happened during medication error; -NM re-educated LPN#1 on patient identifiers as well as confirmation of dose to decrease chance of dosing errors. Review on 7/26/18 of client #12's clinical and	V 105		

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V 105	Continued From page 4 medical documentation from 4/1/18-7/25/18 revealed the following: -nursing note dated 6/24/18 completed by LPN#1, not time recorded; -client #12 "received a 50mg difference in dosage today and would not stay to be further assessed;" -"He stated that he'd been on 180mg and that he'd been fine;" -"Called [client #12] to f/u(follow up) and ensure he was ok, [client #12] stated he was fine and had no feelings of oversedation or euphoria;" -"[Physician] notified along with [NM];" -no further documentation of any hourly contact with client #12. Interview on 7/25/18 with client #12 revealed: -works all night in construction; -comes and doses, then goes home to sleep, gets up at 6pm; -problems getting his dose to last all night while he works; -got the wrong dose, got his brother's dose (client #13); -felt fine, no problems, been on 180mg in past with no problems; -nurse called him and checked in him; -actually asked for dose increase since then and made him feel better; -currently on 140mg; -saw physician after he got the wrong dose. Interview on 7/25/18 with the Substance Abuse counselor revealed: -has client #12 on her caseload; -client #12 works nights 14-15 hour shifts, gets off work around 7am-8am, -comes in to dose then goes home to bed; -found out about medication error that Monday(6/25/18); -saw client #12 on Tuesday for a clinical	V 105		

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V 105	Continued From page 5 session(6/26/18); -he was supposed to wait to see physician on Monday but he got inpatient; -refused to wait and went home without seeing the physician; -reported during his session on 6/26/18 he felt fine on higher dose, had no problems with oversedation or euphoria; -he saw physician on Wednesday(6/27/18) after that Sunday of the medication error. Interview on 7/25/18 with the NM revealed: -notified of medication error by LPN#1 over weekend; -client #12 was asked to remain at the clinic to be monitored but he refused and left the clinic; -LPN#1 called the Physician for instructions and followed the policy; -client #12 told LPN#1 not to call him as he was going to bed when he got home; -policy says call client hourly; -LPN#1 did not call hourly; -LPN#1 did call client #1 before she got off work and he reported he was fine; -talked with LPN#1 about medication errors, re-educated her on verifying patient and dose; -have not held a meeting with all the nurses about medication errors or retrained the nursing staff; -talked with them(nurses) individually; -has no documentation of meeting or re-training with the nursing staff. Interview on 7/26/18 with the LPN#1 revealed: -gave client #12 his brother's (client #13) dose, a higher dose; -happened on a weekend; -called client #12 back to window before he left clinic and informed him of dose error; -client #12 refused to remain at clinic for assessment;	V 105		

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V 105	Continued From page 6	V 105		

-told client #12 to seek medical attention if he felt oversedation or euphoria;
-called NM and the Physician;
-the Physician instructed her to continue to monitor client #12;
-called client #12 maybe 1-2 times to check on him;
-client #12 told her he was fine and to stop calling him;
-client #12 told her ,"I've been working, I'm tired exhausted, going home to sleep;"
-placed note in computer for the Physician.

Interview on 7/26/18 with LPN#2 revealed:
-works on weekends and also during week;
-aware of medication error protocol;
-not sure about details, should ask NM, she knows;
-know if give incorrect dose, call the Physician;
-try to keep client at the facility for assessment for oversedation;
-do need to call clients to check on then after they leave clinic;
-not sure how often need to call, " maybe every couple of hours. "

Interview on 7/26/18 with the Physician revealed:
-LPN#1 notified him of medication error;
- " alittle scary...pretty good hit...big jump; "
- " look at whole picture...individual thing; "
-oversedation would be issue of concern with this medication error,especially if client is driving;
-with client #12, been on a high dose in past;
-client #12 had not reached a stable dose yet;
-worked out for this client as he felt better on higher dose, did increase his dose afterwards;
-had a tolerance for higher doses;
-told LPN#1 to keep an eye on client #12 and monitor him;
-LPN#1 was going to call him and check on him;

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V 105	Continued From page 7 -especially important to call at peak time, 2-3 hours after he doses; -not sure if LPN#1 actually reached client #12; -saw client #12 that week and he was fine. Review on 7/26/18 of a medical note dated 6/28/18 completed by the Physician revealed the following documented: -current dose 120mg; -"lasting till 11pm since getting a higher dose last weekend by accident; Been in 180mg in the past while on 3rd shift. Now back on 3rd shift and not lasting; The higher dose he got last week (170mg) did well at work for next 2 days...increase dose;" -change dose on 6/28/18 to 130mg; -change dose on 6/30/18 to 140mg. Review on 7/27/18 of a Plan of Protection dated 7/27/18 and completed by the Program Director revealed the following documented; - " With respect to rule violation cited: 10ANCAC 27G.0201 Governing Body Policies V105 with cross reference: 10ANCAC 27G.0209 medication requirements V118. In order to protect patients from further risk or harm Nursing Services Coordinator will immediately (48 hours) retrain all pharmacy staff on policies of: Medication distribution errors and Patient verification. This training will be evidenced by review of agency policy and procedure along with sign-in sheet signature documentation/confirmations; " - " In order to verify that this training has taken place, Program Director will follow up with Nursing Services Coordinator for confirmation. In addition, Program Director will attach further subsequent re-trainings to all incident reports in an effort to reduce risk while continuing to provide exceptional patient care. "	V 105		

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V 105	Continued From page 8 LPN#1 administered client #12 the wrong dose of methadone, increasing his dose from 120mg to 170mg on 6/24/18. Client #12 refused to remain at the clinic for ongoing assessment, informed LPN#1 he was going home to bed after working all night and told LPN#1 not to call him. The Physician ordered client #12 to be monitored especially at the peak time two to three hours after dosing for oversedation. LPN#1 did not follow the established protocol on medication errors as she did not call client #12 hourly as required to monitor for oversedation as requested by the Physician. The medication error and lack of implementation of the medication error protocol was detrimental to the health, safety and welfare of client #12 and constitutes a Type B rule violation and must be corrected within 45 days. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 105		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and	V 118		

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V 118	Continued From page 9 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 records review and interviews, the facility failed to ensure medications were administered as ordered and Nurses demonstrated competency for the population served for 1 of 2 Licensed Nurse Practitioners (LPN#1) affecting 1 of 13 current audited clients (#12). The findings are: Review on 7/25/18 of LPN#1's personnel record revealed: -hire date of 7/5/16 with job title of Dosing Nurse part time weekends; -single state LPN license with expiration date of 11/30/19; -completed trainings in Policies and Procedures, Dosing Procedures and Patient Identifiers on 7/6/16.	V 118		

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V 118	Continued From page 10 Review on 7/25/18 of client #12's record revealed: -admission date of 9/19/16 with diagnoses of Opioid Use Disorder; -admission assessment/physician evaluation dated 9/19/16 documented use of oxycodones 300mg daily for 30 years, cocaine use, prior Opioid treatment in 2005, 2014 and 2015, past surgeries on right wrist and right knee, arthritis and no prescription medications; -updated physician evaluation dated 12/27/17 documented continued problems with arthritis, COPD (Chronic Obstructive Pulmonary Disease), Attention Deficit Hyperactivity Disorder, uses an inhaler, denies any current legal issues, mental health issues, suicidal ideations and self injurious behaviors; -updated assessment dated 12/29/17 documented has a primary care physician, works construction, has no history of overdose, denies mental health issues, past usage of pain pills, divorced, past surgeries on wrist and knee; -treatment plan dated 5/8/18 documented goals of establish new coping skills to mange anxiety, clarify strategies to use to change from active drug use to recovery. Review on 7/25/18 of client #12's MARs from 1/1/18-7/24/18 revealed the following doses and dose increases with matching physicians' orders: -1/9/18 60mg; -1/20/18 65mg; -1/24/18 70mg; -2/15/18 80mg; -2/22/18 90mg; -4/24/18 100mg; -6/5/18 110mg; -6/21/18 120mg; -6/28/18 130mg; -6/30/18 140mg;	V 118		

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V 118	Continued From page 11 -7/24/18 140mg. Review on 7/25/18 of client #12's urine drug screens from 4/1/18-7/16/18 revealed the following results: -4/2 clean; -5/22 cocaine; -6/4 cocaine, amphetamines, fentanyl; -7/16 cocaine, marijuana. Review on 7/25/18 of the facility incident reports from 5/1/18-7/25/18 revealed an incident report dated 6/24/18 (Sunday) regarding client #12 documenting the following: -LPN#1 reported to Nurse Manager (NM) client #12 entered dosing window, stated his name and number and LPN#1 clicked his name; -client #12 signed signature pad and was dosed; -client #12's brother (client #13) came up to dose and when entered him into the computer, it said he had already dosed; -LPN#1 determined client #12 received client #13's dose of 170mg instead of his physician ordered dose of 120mg. Review on 7/25/18 of client #13's record revealed: -admission date of 1/27/16 with diagnoses of Opioid Use Disorder; -physician's order dated 1/17/18 for increase to 170mg daily. Review on 7/25/18 of client #13's MARs from 1/1/18-7/24/18 revealed daily doses of 170mg documented as administered. Interview on 7/25/18 with client #13 revealed: -been coming to the facility for over a year; -currently on 140mg; -work construction 12 hours at night;	V 118		

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V 118	Continued From page 12 -have problems with dose lasting through the night while he works; -got wrong dose one time recently; -received his brother's(client #13) dose of 170mg instead of his 120mg; -"was an accident;" -only time it has happened; -felt fine, no problems. Interview on 7/25/18 with the NM revealed: -received a call from LPN#1 over one weekend about a medication error; -LPN#1 informed her client #12 had received his brother's dose (client #13); -LPN#1 reported she verified client #12's identification and dose, clicked on his name on the computer and thought she clicked on right one; -clicked on client #13's dose instead and client #12 got a high dose than he was prescribed; -fixed problem in computer and client #13 got his correct dose. Interview on 7/26/18 with LPN#1 revealed: -work on weekends, every other weekend, Saturday and Sunday from 545am-9am; -one weekend on a Sunday, client #12 and client #13 came in, they are brothers; -their names are next to each other in the computer; -client #12 came to dose at her window, verified his name and information; -thought clicked on his name in computer but must have clicked on client #13; -client #12 got client #13's higher dose; -caught if before client #12 left; -client #12 said he was fine. This deficiency is cross referenced into 10A NCAC 27G .0201 GOVERNING BODY	V 118		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE TREATMENT CENTER, INC.	3315 WILKINSON BLVD. CHARLOTTE, NC 28208

(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 118	Continued From page 13 POLICIES V105 for a Type B violation and must be corrected in 45 days.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure before hiring health care personnel, the Health Care Personnel Registry (HCPR) was accessed. The findings are: Review on 7/26/18 of personnel files revealed: -Cashier was hired on 6/25/18 with job title of Part Time Weekend Cashier; -HCPR was completed on 7/25/18. Interview on 7/26/18 with the Program Director revealed the Cashier has worked two weekends so far. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 131		