STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 7/27/18. The complaint was unsubstantiated (intake #NC00139847). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment, 10A NCAC 27G . 4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G . 4500 Substance Abuse Comprehensive Outpatient Treatment Program The client census was 428 at the time of the survey.	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;	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 105	Continued From page 1 (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 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;	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policy regarding testing positive for Benzodiazepine. The findings are: Review on 7/26/18 of the facility's policy on Benzodiazepine revealed the policy included the following components: -"All patients testing positive for illicit Benzodiazepines are to meet with the Medical Director of the clinic(s) within (7) days of the results. Patients will meet monthly with the physician until no longer test positive for Benzodiazepines." -"Patients testing positive for Benzodiazepine 4-6 months post admission are to be referred to Medical Director of the clinic(s). The amount and type of Benzodiazepine will be ascertained, understanding that both are inaccurate during the initial interview of the patient." -"Patients testing positive for illicit Benzodiazepines will have weekly documented counseling sessions until they no longer test positive for Benzodiazepines." Review on 7/26/18 of Deceased Client (DC) #21's chart revealed: -Admission date of 8/9/16. -Diagnoses of Opioid Dependence; Cocaine Use Disorder; Bipolar Disorder; Borderline Personality Disorder, Diabetes; Hypothyroidism. -DC #21 died on 5/22/18. -Methadone dosage was 50 mg. Review on 7/25/18 of an incident report for DC #21 revealed: -Date of Incidence: 5/22/18.	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 105	Continued From page 3 -Location of the Incident: Consumer's Home. -Level of Incident: Level III. -Suspected Cause of Death: Accidental Overdose -DC #21 dosed at 50 mg that morning and apparently died in afternoon. -DC #21's roommate stated that she had been using benzodiazepines, cocaine and heroin, and staying with an abusive boyfriend. Review on 7/26/18 of DC #21's Urine Drug Screens (UDS) revealed: -5/8/18 was positive for Benzodiazepine, Cocaine and Codeine. -3/28/18 was positive for Benzodiazepine and Cocaine. -2/5/18 was positive for Benzodiazepine and Cocaine. -1/9/18 was positive for Benzodiazepine and Cocaine. -12/15/17 was positive for Benzodiazepine and Alcohol. -11/9/17 was positive for Benzodiazepine and Cocaine. -10/27/17 was positive for Benzodiazepine and Alcohol. -9/7/16 was positive for Benzodiazepine and Alcohol. -8/9/16 was positive for Benzodiazepine. Review on 7/26/18 of DC #21's list of medications revealed: -Insulin 60 units daily. -Neurontin 600 mg- Three times a day. -Cymbalta 60 mg- One tablet daily. -Synthroid 275 mcg- One tablet daily. -Trazodone 200 mg- One tablet at night. -Seroquel 200 mg- One tablet in the morning. -Seroquel 400 mg- One tablet at night. -No Benzodiazepine medication was being prescribed.	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 105	Continued From page 4 Review on 7/26/18 of DC #21's case notes revealed: -She met with the counselor on 12/27/17, 3/27/18, 5/8/18 and 5/22/18. -She met with the physician assistant on 1/19/18. -She met with the physician on 1/22/18 and 5/8/18. -Physician did not meet with DC #21 within seven days after she tested positive for Benzodiazepine. -There were no weekly documented counseling sessions while DC #21 continued to test positive for Benzodiazepine. -There were no monthly meetings with the physician while DC #21 continued to test positive for Benzodiazepine. Interview on 7/25/18 and 7/27/18 with the Counseling Supervisor revealed: -The Clinic staff were informed on 5/24/18 that DC #21 had died from an overdose on 5/22/18. -DC #21 had dosed at the clinic on 5/22/18. -She met with DC #21 on 5/22/18 prior to her death. -She talked with DC #21 about Narcan. -DC #1 seemed to be "dismissive" and told her she already had Narcan. -The clinic staff were aware DC #21 consistently tested positive for Benzodiazepines and other substances. -The Clinic Physician did not meet with DC #21 within seven days after she tested positive for Benzodiazepine. -A former Counselor did meet with DC #21 for continued Benzodiazepine use, however it was not on a weekly basis. -She was aware there were no weekly documented counseling sessions for continued positive testing of Benzodiazepines. -She was aware there were no monthly meetings	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 105	Continued From page 5 with the physician while DC #21 continued to test positive for Benzodiazepines. -She confirmed the facility failed to follow their Benzodiazepine policy for DC #21. Interview on 7/27/18 with the Clinic Director confirmed: -Facility staff failed to follow Benzodiazepine policy for DC #21. Review on 7/27/18 of a Plan of Protection written by the Counseling Supervisor and Clinic Director dated 7/27/18 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm: "Effective 7/27/18, a Methasoft report will be run daily, identifying all benzodiazepine positive patients' drug screens for that day. All patients testing positive will be placed on hold in Methasoft, will see their Counselor prior to dosing. Session will be held with Counselor regarding benzodiazepine positive results. An Appointment will be scheduled during the Counselor session with [Medical Director] that will fall within the seven day requirement." Describe your plans to make sure the above happens: "A spread sheet will be developed and maintained that includes all patient record numbers/names that tested positive for benzodiazepines. Spreadsheet will include a column for the follow-up date with the Counselor as patient verification. Date of [Medical Director] appointment schedule will be included on spreadsheet. Column to ensure [Medical Director] appointment took place will be included on the spreadsheet. Spread sheet will be monitored by [Counseling Supervisor] daily. Spread sheet will be monitored weekly (Fridays) by [Clinic Director]."	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 105	Continued From page 6 DC#1 had diagnoses of Opioid Dependence, Cocaine Use Disorder, Bipolar Disorder, Borderline Personality Disorder, Diabetes and Hypothyroidism. DC #21 died on 5/22/18. It was reported that DC #21 died from an apparent overdose. Prior to her death DC #21 tested positive for Benzodiazepines and other substances seven times since 10/27/17. DC #21 did not meet with the Medical Director monthly as stated in the Benzodiazepine policy. DC #21 did not meet with a Counselor on a weekly basis as stated in the Benzodiazepine policy. The Clinic staff did not follow their policy to address continued use of Benzodiazepines. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $6000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 105		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 114	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Review on 7/25/18 of the facility's fire and disaster drills record revealed: -There were drills conducted on the following dates: -3/31/17 and 4/25/18 - 1st shift fire drill -5/18/17 and 6/28/18 - 1st shift disaster drill -Fire and Disaster drills were not conducted at least quarterly. Interview on 7/27/18 with the Clinic Director revealed: -She was new to the position as of February 2018. -She was unaware fire and disaster drills needed to be conducted quarterly. -The facility operated on one shift. -She confirmed fire and disaster drills were not conducted at least quarterly.	V 114		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 235	Continued From page 8 certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients, facility failed to ensure at least one staff member on duty had training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction affecting two of nine audited staff (The Lead Nurse and Nurse #1) and failed to ensure each direct care staff member received continuing education in nature of addiction and the withdrawal syndrome affecting two of nine audited staff (The Lead Nurse and Nurse #1). The findings are: 1. The following is evidence the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients.	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 235	Continued From page 9 Review of facility records on 7/25/18 revealed: -The facility had a census of 428 clients. -The facility currently had five full time substance abuse counselors. -Counselor #1 had a caseload of 75 clients. -Counselor #2 had a caseload of 75 clients. -Counselor #3 had a caseload of 74 clients. -Counselor #4 had a caseload of 75 clients. -Counselor #5 had a caseload of 74 clients. Interview on 7/25/18 with the Counseling Supervisor revealed: -She did currently have a caseload of clients due to the Counselor vacancies. -She thought Counselors who had more than 50 on their caseloads just occurred within the last month. -She confirmed the facility failed to ensure there was a ratio of one counselor to every 50 or less clients. Interview on 7/25/18 with the Clinic Director revealed: -The clinic currently has three vacant counselor positions. -The Counseling Supervisor had taken on a caseload of clients. -She had also taken on a caseload of clients. -Some of the Counselors did have more than 50 clients on their caseload. -She thought there were at least three Counselors who had more than 50 clients on their caseload. -She confirmed the facility failed to ensure there was a ratio of one counselor to every 50 or less clients. 2. The following is evidence the facility failed to ensure at least one staff member on duty had training in drug abuse withdrawal	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 235	Continued From page 10 symptoms/symptoms of secondary complications to drug addiction. a. Review on 7/25/18 of the facility's personnel files revealed: -The Lead Nurse had a hire date of 7/31/10. -There was no documentation of training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. b. Review on 7/25/18 of the facility's personnel files revealed: -Nurse #1 had a hire date of 12/27/17. -There was no documentation of training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. Interview with the Clinic Director on 7/25/18 revealed: -She was not aware of Nurses needing the training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. -She confirmed the Lead Nurse and Nurse #1 had no training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. 3. The following is evidence the facility failed to ensure each direct care staff member received continuing education in nature of addiction and the withdrawal syndrome. a. Review on 7/25/18 of the facility's personnel files revealed: -The Lead Nurse had no documentation of continuing education in nature of addiction and the withdrawal syndrome. b. Review on 7/25/18 of the facility's personnel	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAART COMMUNITY HEALTHCARE	800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701

(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 235	Continued From page 11 files revealed: -Nurse #1 had no documentation of continuing education in nature of addiction and the withdrawal syndrome. Interview with the Clinic Director on 7/25/18 revealed: -She was not aware of Nurses needing the continuing education in nature of addiction and the withdrawal syndrome. -She confirmed the Lead Nurse and Nurse #1 had no continuing education in nature of addiction and the withdrawal syndrome.	V 235		