/Appendix 1-B: Plan of Correction Form

Plan of Correction	
Please complete all requested information and mail completed Plan of Correction form to: **Mental Health Licensure and Certification Section** **NC Division of Health Service Regulation** **2718 Mail Service Center** **Raleigh, NC 27669-2718**	**In lieu of mailing the form, you may e-mail the completed electronic form to: plans.of.correction@dhhs.nc.gov**

Provider Name:	**ATS of NC dba Carolina Treatment Center of Pinehurst**	**Phone:**	**910-235-9090**
Provider Contact Person for follow-up:	**Jessica Tighe, Clinic Director**	**Fax:**	**910-235-9093**
		Email:	**Jessica.tighe@ctcprograms.com**
Address:	20 Page Drive Suite 7&8 Pinehurst, NC 28374	**Provider #** MHL – 063-065	

Finding	Corrective Action Steps	Responsible Party	Time Line
V112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interview, the facility	V112 To correct this discrepancy and ensure that all clients have a written plan within 30 days, a Person-Centered Plan (PCP) and Crisis Prevention and Intervention Plan (CCP) will be developed with each client prior to admission to the program. The PCP and CCP for each new admission will be reviewed by the clinical manager upon the day of admission to ensure completion of all required components and involvement of all required parties (patient, counselor, medical providers). To ensure that PCPs and CCPs are reviewed and updated in a timely manner to prevent gaps in documented services, each clinician will be required to submit a monthly report to include all PCPs/CCPs which are current due for an update or past due. Each patient requiring an update will then be flagged to schedule an appointment immediately to complete the update. Should the patient fail to keep the scheduled appointment, the patient will then be placed on a "stop dose" until a counselor is available to complete the required update. Clinical manager will conduct in-service training via group supervision to ensure that all clinicians are knowledgeable of and familiar with the required update schedule.	Jason Hines, CSAC, Clinical Manager. DHSR - Mental Health SEP 04 2018 Lic. & Cert. Section	Implementation Date: 8/1/2018 Projected Completion Date: 9/1/2018

failed to develop a plan for one of twenty audited clients (#2) and failed to schedule a review of a plan at least annually for one of twenty audited clients (#1). The findings are: 1. The following is evidence the facility failed to develop a plan for a client. Review on 6/20/18 of client #2's record revealed: -Admission date of 10/11/13. -Diagnosis of Opioid Use Disorder. -There was no documentation of a plan developed for client #2. Interview on 6/20/18 with the Clinic Director revealed: -She was not sure why there was no plan developed for client #2. -She confirmed the facility failed to develop a plan for client #2. 2. The following is evidence the facility failed to schedule a review of a plan at least annually. Review on 6/20/18 of client #1's record revealed: -Admission date of 7/11/11. -Diagnoses of Opioid Use Disorder and Bipolar Disorder. -Client #1 had a Person Centered Plan dated 3/13/17. -There was no documentation that client #1 had a current plan in her record. Interview on 6/20/18 with the Clinic Director revealed: -Client #1 was having some issues. -She thought the issues were related to some type of personal crisis. -Client #1 had not been able to meet with her Counselor. -The Counselor did not develop a current plan for client #1. -She confirmed the facility failed to schedule a review of a plan at least annually for client #1.			
V536 27E .0107 Client Rights - Training on Alt to Rest.Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers,	V536 To correct and prevent this deficiency, Clinic Director has become a trainer for Safety Care. This will allow all employees to receive training in an appropriate time frame. Employees will be required to attend a training prior to patient contact and will need recertification annually.	Jessica Tighe, Clinic Director	Implementation Date: 6/1/2018 Projected Completion Date: **9/1/2018**

employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;			

(7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of:			

(A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure one of nine audited staff (Counselor #2) had training on the use of			

alternatives to restrictive interventions prior to providing services and failed to ensure two of nine audited staff (Counselor #1 and the Nurse Manager) had current training on the use of alternatives to restrictive interventions. The findings are: 1. The following is evidence the facility failed have training on the use of alternatives to restrictive interventions prior to providing services. Review on 6/20/18 of the facility's personnel files revealed: -Counselor #1 had a hire date of 10/16/17. -There was no documentation that Counselor #2 had training on the use of alternatives to restrictive interventions. 2.The following is evidence the facility failed to ensure staff had current training on the use of alternatives to restrictive interventions. a. Review on 6/20/18 of the facility's personnel files revealed: -Counselor #1 had a hire date of 2/22/12. -Counselor #1 had North Carolina Intervention training that expired 6/7/18. -There was no documentation that Counselor #1 had current training on the use of alternatives to restrictive interventions. b. Review on 6/20/18 of the facility's personnel files revealed: -The Nurse Manager had a hire date of 9/8/14. -The Nurse Manager had a training in North Carolina Interventions that expired 2/15/18. -The Nurse Manager had a training in Safety Care Behavioral Safety that was completed on 5/21/18. -There was a three month lapse in training on the use of alternatives to restrictive interventions for the Nurse Manager. Interview with the Clinic Director on 6/20/18 and 8/9/18 revealed: -The agency uses Safety Care Behavioral Safety training on the use of			

alternative to restrictive intervention. -The agency just recently started using Safety Care Behavioral Safety training. -She was the trainer for Safety Care Behavioral Safety training. -Not all staff had the training because she could only have 10 people at a time in a class. -She confirmed Counselor #2 had no training on the use of alternatives to restrictive interventions prior to providing services. -She confirmed Counselor #1 had no current training on the use of alternatives to restrictive interventions. -She confirmed the Nurse Manager had a lapse in training on the use of alternatives to restrictive interventions.			
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