STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-282	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON TREATMENT CENTER	2200 CLYBOURN CHURCH ROAD LUMBERTON, NC 28358

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on October 8, 2018. The complaint was unsubstantiated (intake #NC00142260). A deficiency was cited. This facility is licensed for the following category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. The census at the time of the survey was 309.	V 000		
V 122	27G .0209 (G) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (g) Medication education: (1) Each client started or maintained on a medication by an area program physician shall receive either oral or written education regarding the prescribed medication by the physician or their designee. In instances where the ability of the client to understand the education is questionable, a responsible person shall be provided either oral or written instructions on behalf of the client. (2) The medication education provided shall be sufficient to enable the client or other responsible person to make an informed consent, to safely administer the medication and to encourage compliance with the prescribed regimen. (3) The area program physician or designee shall document in the client record that education for the prescribed psychotropic medication was offered and either provided or declined. if provided, it shall be documented in what manner it was provided (either orally or written or both) and to whom (client or responsible person).	V 122	In order to correct this deficiency, on the medication protocol form, the nurse will educate the patient about any medication changes and the patient will initial the appropriate order showing current dose and what the dose will be changed to. This will be monitored by the program director, Stephanie Sanderson every month. Macy Hamm, CEO 10/17/18	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Stephanie Sanderson LPC, LCASA 10.17.18

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V 122	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to inform or provide education regarding prescribed medication dosage changes sufficient to encourage compliance with the prescribed regimen for 1 of 15 audited clients (client #721). The findings are: Review on 10/8/18 of client #721's record revealed: -39 year-old male. -Admission date 2/16/17. -Diagnoses of Opioid dependency. -Prior to 8/7/18 client #721 had been receiving Methadone 145 mg daily. -8/7/18 client #721 had multiple teeth extracted. Fentanyl was administered for dental procedure sedation. -8/8/18 client #721 presented his bottle of pain medicine prescribed for post dental procedure pain to the dosing nurse . The bottle label read there were 20 tablets of Hydrocodone dispensed on 8/8/18 (day following client's procedure) with directions to take 4 - 6 tablets per day as needed. There were 15 tablets in the bottle. -8/8/18 the physician was informed of the discrepancy of the Hydrocodone dispense date and the number of tablets on hand. Coordination of care forms were sent to the dentist and pharmacy per the physician's request. -8/9/18 Pharmacy faxed a listing of client #721's medications; it documented the dispense date for Hydrocodone was 8/8/18. -8/9/18 - 8/11/18 nurses documented daily counts of client #721's Hydocodone tablets. The count decreased 5 tablets per day, in compliance with the order. -8/11/18 nurses documented client #721 had no more Hydocodone tablets.	V 122		

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V 122	Continued From page 2 -8/13/18 physician documented review of client #721's drug screen collected on 8/8/18. The results documented client #721 was positive for Oxycodone, Noroxycodone, Oxymorphone, and Noroxymorphone on 8/8/18, the day following his dental procedure. -8/13/18 physician ordered to start a taper down of client #721's Methadone dose by 1 mg every other day until his dose was 140 mg, "due to misuse of hydrocodone and norfentanyl positive." -No documentation the physician, nurse, counselor, or any other staff informed client #721 his dose would decreased from 145 mg to 140 mg prior to the initiation of the taper. Review of client #721's medication Administration record between 7/1/18 to 10/8/18 revealed: -Client #721 received Methadone 145 mg between 7/1/18 - 8/13/18. -8/11/18 nurse documented, "0 pain pills left." -8/14/18 (Tuesday) Methadone dosage decreased to 144 mg. No notes documented about dosage change. -8/16/18 (Thursday) Methadone dosage decreased to 143 mg. No notes documented about dosage change. -8/18/18 (Saturday) Methadone dosage decreased to 142 mg. No notes documented about dosage change. -8/20/18 (Monday) Methadone dosage decreased to 141 mg. No notes documented about dosage change. -8/22/18 (Wednesday) Methadone dosage decreased to 140 mg. No notes documented about dosage change. Review on 10/8/18 of client #721's Case Notes dated 8/20/18 revealed: -Program Director documented client was "angry and hostile" because his Methadone dose had	V 122		

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V 122	Continued From page 3 been changed. Interview on 10/7/18 client #721 stated: -8/7/18 he had 14 teeth "cut out." The dentist prescribed Vicoprofen (hydrocodone and ibuprofen tablet) 7.5 mg for pain. -8/8/18 he brought in his pain medication for the nurse to check. -The nurse said the bottle was dated 8/8/18. He told the nurse he had his prescriptions filled on 8/7/18 after the procedure. -Because of this "mix up" they had dropped his dose by 5 mg. -He was not informed of the order to drop his dosage. It was on a week end, he told the dosing nurse his dose was 145 mg. The week end nurse told him his dose had been decreased. This was the first time anyone told him the doctor had written an order to decrease his dose. -He had experienced cold sweats, nausea, and felt like he "dragged more" that prior week when they had decreased his dose. -He was told he could not have his dose increased until he saw the doctor again. -He had not seen the doctor or had his dose increased. Interview on 10/8/18 Staff Nurse #4 stated: -She thought client #721 went to dentist after he was dosed at the clinic 8/7/18. Client #721 had informed staff he he was having the rest of his teeth removed and she informed him to bring in any medications for a pill count and to make sure the medication was taken correctly. -8/8/18: He came in and brought in his medication. The bottle read 20 tablets dispensed. The bottle was dated 8/8/18, meaning he picked up the medication on that day. Client #721 insisted he got his medication on 8/7/18. The prescription was to take 1 tablet every 4-6 hours.	V 122		

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V 122	Continued From page 4 If he had gotten them on 8/7/18 he would have been able to take 5 tablets, but given he filled on 8/8/18, it showed he took 5 tabs on 8/8/18 before coming to the clinic. Dosing history documented he was dosed at 10:51 am on 8/8/18. He signed for them to get a copy of his dosing history from pharmacy. -The physician would have been at clinic on 8/8/18. The physician wanted to get the response back from pharmacy before she started a taper. Client #721 was continued at 145 mg daily until paper work returned, then his dose was tapered. -The client must bring in their medication for a controlled drug every day until they no longer take the med. Client #721 complied and his medication was counted each day and compared with the order. On 8/11/18 the comment of "0 pain pills left" would indicate he completed the script. -The physician was probably in the office on Monday, 8/13/18, when she wrote the order to taper client #721's dosage. -In this case the client would be referred to his counselor to explain his order change. The nurse would not explain this to the client. Referring the client to his counselor is done to prevent clients from getting upset at the dosing window. -She put client #721"on hold" to see his counselor prior to his taper that started on 8/14/18. -Assessments were not performed for withdrawal when a client's dose is being tapered down. Interview on 10/8/18 client #721's counselor, Counselor #11 stated: -He remembered Staff Nurse #4 calling and telling him client #721 was starting a "taper." -The taper was for misuse of meds and to drop his dose while taking his pain pills. -Counselor #11 did not inform client #721 of the taper. -The nurse would be the person responsible to	V 122		

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V 122	Continued From page 5 inform the client his dose was being tapered. Interview on 10/8/18 the Program Director stated: -When a client's dose is decreased by the physician and it was not because of a patient request, it was better if the counselor explained this to the client before the client was told at the dosing window. -If the counselor did not explain this to the client, the nurse should "catch this" when the client stated their dose prior to dosing. The nurse in this case would make the client aware of the dosage change before he/she was dosed.	V 122		