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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on October 29, 2018. The complaint was unsubstantiated (Intake NC142952). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. The current census at the facility is 229 clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.	V 109		

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V 109	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 8 Qualified Professionals (Staff #17) display the knowledge, skills and abilities required by the population served. The findings are: Review on 10/19/18 of Staff #17's record revealed: -Hire date of 11/2/15; -Hired as Counselor; -Certification as a Substance Abuse Counselor. Review on 10/17/18 of Client #10's record revealed: -Admission date of 6/5/15; -Diagnosis of Opioid Dependence; -Case note dated 9/21/18 written by Staff #17 documenting client's notification to facility of hospitalization for pneumonia and symptoms of congestive heart failure. Client expressed concern about how to self-administer take home doses after discharge from the hospital; -Treatment team minutes involving Medical Doctor #20 and Staff #17 discussing Client #10's recent hospitalization with clear directive from Medical Doctor #20 to notify Client #10 to bring all	V 109		

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unopened take home doses back to the facility upon hospital discharge and that the take home doses will be disposed of at the facility and replaced at no charge to the client;
-Case note dated 9/25/18 written by Staff #17 documenting Client #10 was still in the hospital and was instructed to maintain telephone contact with Staff #17;
-Case note dated 10/4/18 written by Staff #17 documenting attempts to reach Client #10 as Client #10 has not contacted the facility again. An additional case note dated 10/4/18 written by Staff #17 documenting that Client #10 returned the call and is out of the hospital and back at home and plans to return to the clinic on 10/5/18;
-Case note dated 10/5/18 written by Staff #17 documenting Client #10's dose decrease from Methadone 150mg daily to 30mg daily. Client #10 was upset and Staff #17 acknowledged that Client #10 was not informed that " ...dose would be decreased in this way if she did not bring in take homes, although counselor (Staff #17) did discuss bringing in unopened bottles and discarding of them and not being recharged for doses. Counselor apologizes for the miscommunication and empathizes and offers understanding for client's frustration and confusion ..."
-No case note documentation of Staff #17 relaying information to Client #10 regarding the instructions from Medical Doctor #20 to return all unopened take home doses of Methadone to the clinic after discharge from the hospital.

Review on 10/16/18 of the Patient Handbook last reviewed and updated on 8/7/18 revealed:
-" ...Illness or Hospitalization ...In case of emergency hospitalization, patients should have staff contact clinic so that treatment may continue ..."

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V 109	Continued From page 3 -There is no documentation instructing clients to return all take home doses to the clinic after hospitalization. Interview on 10/16/18 with Client #10 revealed: -Methadone dose was decreased from 150mg to 30mg daily after her recent hospitalization; -Suffered severe withdrawal symptoms including " ...vomiting, diarrhea, not sleeping, unable to eat due to the vomiting, cramps in hands and feet, restlessness, felt like the flu ...;" -Denied being told by Staff #17 that she was to return all take home doses to the facility after being discharged from the hospital and that the facility would replace all take home doses free of charge. Interview on 10/19/18 with Staff #17 revealed: -Spoke with Client #10 and instructed Client #10 to return all take home doses to the facility after being discharged from the hospital and that the facility would replace all take home doses free of charge; -" ...My fault not in notes ...don't know why it would not be in my notes ...;" Interview on 10/19/18 with the Medical Doctor #20 revealed: -Instructed Staff #17 to inform Client #10 that Client #10 was to return all take home doses to the facility after being discharged from the hospital and that the facility would replace all take home doses free of charge; -Did not want Client #10 to self-administer the take home doses as there is a specific date for self-administration on each bottle and Client #10 would be self-administering medication doses intended for the wrong date with increased risk of improper self-administration; -Was concerned that Client #10 was	V 109		

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V 109	Continued From page 4 non-compliant with her medical treatment (sleep apnea and follow up for a lung nodule) and was recently hospitalized for several days in intensive care as a result of bilateral pneumonia and symptoms of congestive heart failure and recent peak and trough testing indicated possible Methadone toxicity. All this, coupled with the diagnosis of Hepatitis C, was clinically concerning to Medical Doctor #20 and Medical Doctor #20 wanted to ensure coordination of care across all spectrums. Interview on 10/29/18 with the Program Director revealed: -Will ensure proper documentation of treatment decisions and notification of the clients regarding returning take home doses to the clinic after hospitalizations.	V 109		
V 112	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;	V 112		

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V 112	Continued From page 5 (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 interview and record review, the facility failed to ensure treatment plans included staff responsibilities for treatment goals, that all treatment plans were current affecting 10 of 11 audited clients (Client #1, #2, #4, #5, #6, #7, #8, #9, #10, and Deceased Client #11). The findings are: Review on 10/17/18 of Client #1's record revealed: -Admission date of 10/27/10; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #2's record revealed: -Admission date of 4/26/13; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #4's record revealed: -Admission date of 7/8/16; -Diagnosis of Opioid Dependence;	V 112		

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V 112	Continued From page 6 -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #5's record revealed: -Admission date of 4/11/16; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #6's record revealed: -Admission date of 10/6/09; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #7's record revealed: -Admission date of 12/8/14; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #8's record revealed: -Admission date of 10/16/17; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Client #9's record revealed: -Admission date of 11/5/15; -Diagnosis of Opioid Dependence; -Treatment plan review was scheduled for September, 2018 and was never completed. Review on 10/17/18 of Client #10's record revealed:	V 112		

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V 112	Continued From page 7 -Admission date of 6/5/15; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Review on 10/17/18 of Deceased Client #11's record revealed: -Admission date of 7/25/12; -Date of death of 9/24/18; -Diagnosis of Opioid Dependence; -No staff responsibilities documented in the treatment plan strategies. Interview on 10/29/18 with the Program Director revealed: -Will follow up with all counselors to ensure that clients have the current treatment plans and that all staff responsibilities be clearly documented in the treatment plans. This deficiency constitues a re-cited deficiency and must be corrected within 30 days.	V 112		
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.	V 131		

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V 131	Continued From page 8 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Health Care Personnel Registry (HCPR) be checked for each staff and note each incident of access prior to an offer of employment affecting 1 of 9 audited staff (Staff #17). The findings are: Review on 10/19/18 of Staff #17's record revealed: -Hire date of 11/2/15; -Hired as Counselor; -HCPR check completed on 3/22/17. Interview on 10/29/18 with the Program Director revealed: -Currently ensures that the HCPR check is completed prior to an offer of employment for all staff.	V 131		
V 238	27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program approval on the following criteria: (1) compliance with all state and federal law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the	V 238		

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specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month.

(1) Levels of Eligibility are subject to the following conditions:

(A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic;

(B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week;

(C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week;

(D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five take-home doses and shall ingest all other doses under supervision at the clinic each week;

(E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be

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V 238	Continued From page 10 granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and (G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month. (2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility: (A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility by one level of eligibility; (B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and (C) The reinstatement of take-home eligibility shall be determined by each Outpatient Opioid Treatment Program. (3) Exceptions to Take-Home Eligibility: (A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a	V 238		

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V 238	Continued From page 11 verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous treatment. (B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall make monthly clinic visits. (4) Take-Home Dosages For Holidays: Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following: (A) An additional one-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday. (B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above. (g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter. (h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each	V 238		

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V 238	Continued From page 12 active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method. (i) Client Discharge Restrictions. No client shall be discharged from the facility while physically dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug. (j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and	V 238		

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V 238	Continued From page 13 shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for bottle checks, bottle returns or solid dosage form call-in's; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction; (5) client attendance minimums; and (6) procedures to ensure that clients properly ingest medication. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure clients received a minimum of one counseling session per month after their first year in continuous treatment affecting 3 of 11 audited clients (Clients #3, #5, and #9) and failed to ensure that clients received one random drug test per month affecting 1 of 11 audited clients (Client #6). The findings are: Finding #1 Review on 10/17/18 of Client #3's record revealed: -Admission date of 4/15/16; -Diagnosis of Opioid Dependence; -No documentation of a counseling session for September, 2018. Review on 10/17/18 of Client #5's record	V 238		

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SANFORD TREATMENT CENTER, LLC	2800 INDUSTRIAL DRIVE SANFORD, NC 27332

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V 238	Continued From page 14 revealed: -Admission date of 4/11/16; -Diagnosis of Opioid Dependence; -No documentation of a counseling session for August, 2018. Review on 10/17/18 of Client #9's record revealed: -Admission date of 11/5/15; -Diagnosis of Opioid Dependence; -No documentation of a counseling session for September, 2018. Interview on 10/29/18 with the Program Director revealed: -Will follow up with all counselors to ensure that clients have the necessary counseling sessions each month. Finding #2 Review on 10/17/18 of Client #6's record revealed: -Admission date of10/6/09; -Diagnosis of Opioid Dependence; -No documentation of random drug screening for August, 2018. Interview on 10/17/18 with the Registered Nurse #12 revealed: -Client #6 was scheduled for the completion of a drug screen at the facility, but it was never followed up on to ensure completion; -The counselor is responsible for ensuring completion of all drug screens. Interview on 10/29/18 with the Program Director revealed: -Will follow up with all counselors to ensure that clients have the necessary drug screening each month.	V 238		

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V 238	Continued From page 15 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 238		
V 536	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, 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.	V 536		

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V 536	Continued From page 16 (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	V 536		

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V 536	Continued From page 17 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:	V 536		

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V 536	Continued From page 18 (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 interview and record review, the facility failed to ensure that all staff were trained in alternatives to restrictive intervention prior to providing services to clients affecting 6 of 9 audited staff (Registered Nurse #13, Staff #14, Staff #15, Staff #16, Medical Doctor #19, and Medical Doctor #20). The findings are: Review on 10/19/18 of Registered Nurse #13's record revealed: -Hire date of 9/20/18; -No documentation of training in alternatives to restrictive intervention. Review on 10/19/18 of Staff #14's record revealed:	V 536		

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V 536	Continued From page 19 -Hire date of 10/16/18; -Hired as Receptionist; -No documentation of training in alternatives to restrictive intervention. Review on 10/19/18 of Staff #15's record revealed: -Hire date of 9/12/18; -Hired as Counselor; -No documentation of training in alternatives to restrictive intervention. Review on 10/19/18 of Staff #16's record revealed: -Hire date of 9/26/18; -Hired as Counselor; -No documentation of training in alternatives to restrictive intervention. Review on 10/19/18 of Medical Doctor #19's record revealed: -No documentation of training in alternatives to restrictive intervention. Review on 10/19/18 of Medical Doctor #20's record revealed: -Hire date of 4/17/16; -No documentation of training in alternatives to restrictive intervention. Interview on 10/19/18 and 10/29/18 with the Program Director revealed: -Was unable to determine the exact date of hire for Medical Doctor #19; -Did not know that all staff were required to be training in alternatives to restrictive intervention prior to providing services to clients; -A staff training is scheduled for 10/29/18 for alternatives to restrictive intervention and all staff will be trained.	V 536		

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