Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-865	A. BUILDING: ______ B. WING ______	R 10/12/2018

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

Lic. & Cert. Section
NOV 02 2018
DHSR - Mental Health

(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 A follow up survey was completed on 10/12/18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment Current facility client census: 301	{V 000}		
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; (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.	V 112	All clinical staff who manage a case load will receive training specific to treatment planning. This training will take place the first week of Nov. 2018 as evidenced by staff sign in sheet attached to training documents. Training will be conducted by PD. Program Director will also notify the area clinical supervisor of the need to further educate staff on this topic. Program Director will monitor this deficiency and offer feedback and support to clinical staff during indiv. supervision meetings held monthly. CHARLOTTE TREATMENT CENTER Adam Shaver, BA, CSAC Program Director 3315 Wilkinson Blvd. Charlotte, NC 28208 P: 704.697.0044 F: 704.900.7516 adam.shaver@cmglp.com www.NewSeason.com	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] BA, CSAC — TITLE: Program Director — (X6) DATE: 10/29/18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure strategies were developed and implemented to address client needs affecting 2 of 15 clients (#5, #6). The findings are: Finding #1: Review on 10/11/18 of client #5's record revealed: -admission date of 3/3/16 with diagnoses of Opioid Dependence; -history of using heroin and cocaine on and off since 1977; -current dose of 110mg, increased from 100mg on 7/9/18; -no take home doses approved; -several consecutive months of cocaine positive urine drug screens. Review on 10/11/18 of client #5's treatment plan dated 9/5/18 revealed the following goals and strategies: -maintain long term recovery based lifestyle, stay in the process to receive disability, to earn take home doses through appropriately complying with treatment; -staff to give referrals, track dosing, provide clinical sessions, teach long term recovery strategies; -no documentation of specific goals and strategies to address current cocaine usage. Review on 10/11/18 of counselor #1's documentation regarding client #5 revealed the following topics addressed in session: cocaine use, coping skills, relapse triggers, relapse prevention.	V 112		

Division of Health Service Regulation

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V 112	Continued From page 2 Interview on 10/11/18 with counselor #1 revealed: -he planned to place client #5 on a treatment team contract in next week or so to address continued use of cocaine; -he has tried to address it in sessions and still an issue; -client #5 was doing well then relapsed on usage of cocaine; -client #5 has appointment to see the facility physician next week. Finding #2: Review on 10/11/18 of client #6's record revealed: -admission date of 9/19/18 with diagnoses of Opioid Dependence; -history of using heroin daily 1/2 gram; -current dose of 100mg as of 10/9/18; -no take home doses approved. Review on 10/11/18 of client #6's treatment plan dated 9/19/18 revealed the following goals and strategies: -understand self defeating, drug use, use coping skills to deal with life's problems; -examine possibility of cross addictions; -meet weekly with counselor for next 30 days. Review on 10/11/18 of counselor #2's documentation regarding client #6 revealed no documentation client #6 was meeting weekly with counselor. Interview on 10/12/18 with the Regional Director revealed: -has talked several times with counselors about putting specifics in plans to address specific needs of clients including other drug use; -will address treatment plan issues with staff.	V 112		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL060-865 Y1	A. Building B. Wing Y2	10/12/2018

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0105 Reg. # 27G .0201 (A) (1-7) LSC	Correction Completed 10/12/2018	ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 10/12/2018	ID Prefix V0131 Reg. # G.S. 131E-256 (D2) LSC	Correctic Complet 10/12/201
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correctic Complet
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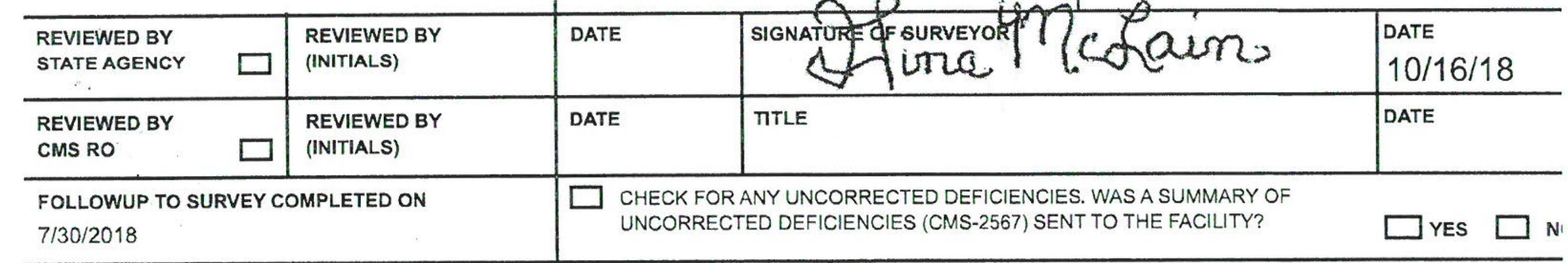

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Lina McLain	DATE 10/16/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/30/2018		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ N