PRINTED: 11/28/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL096-186 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 CAROLINA TREATMENT CENTER OF GOLDSE GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on November 28, 2018. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .3600, Outpatient Opioid Treatment. The census at the time of the survey was 215. V 235 27G .3603 (A-C) Outpt. Opiod Tx. - Staff V 235 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 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

(3)

the following:

(1)

(2)the withdrawal syndrome;

group and family therapy; and

nature of addiction:

(4)infectious diseases including HIV, sexually transmitted diseases and TB.

continuing education to include understanding of

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 11/28/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL096-186 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 CAROLINA TREATMENT CENTER OF GOLDSE GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 235 | Continued From page 1 V 235 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor was on staff to each 50 clients or increments thereof. The findings are: Review of facility records on 11/27/18 revealed: - Current client census of 214. - 5 Counselors with substance abuse certification on staff. - Counselor #1 had a caseload of 57 clients. Counselor #2 had a caseload of 52 clients. - Counselor #3 had a caseload of 52 clients. - Counselor #4 had a caseload of 45 clients. - Counselor #5 had no caseload. - The Clinic Director had a caseload of 9 clients. During interview on 11/27/18 Counselor #1 stated she was hired as a counselor in August 2018. Her caseload of 57 was large and sometimes it was "a little tough to stay on top of things and keep everything up to date." During interview on 11/27/18 Counselor #2 stated he had 52 clients on his caseload and it was manageable. During interviews on 11/27/18 and 11/28/18 the Clinic Director stated Counselor #5 went out on

maternity leave within 90 days of her hire. She was not assigned a caseload prior to her maternity leave because she had not completed her 90 day training period. Assigning and reassigning clients to counselors was not fair to the clients. Upon Counselor #5's return she

This deficiency constitutes a re-cited deficiency

would be assigned a caseload.

PRINTED: 11/28/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_\_ R B. WING MHL096-186 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 CAROLINA TREATMENT CENTER OF GOLDSE GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 235 Continued From page 2 V 235 and must be corected within 30 days.

Division of Health Service Regulation

STATE FORM

# /Appendix 1-B: Plan of Correction Form

	Plan of C	Plan of Correction			
Please complete <u>all</u> 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	rmation and mail completed Plan ification Section ulation	In lieu of mailing the form, you may e-mail the completed electronic form to: plans.of.correction@dhhs.nc.gov	form, you may e-ma rection@dhhs.nc.gov	il the com	pleted electronic
Provider Name:	ATS of NC dba Carolina Treatment	Carolina Treatment Center of Goldshoro	Dhono.	010 503 0330	000
Provider Contact Person for follow-up:			Fax:	919-583-9328	128
			Email:	amber.sass	amber.sasser@ctcprograms.com
Address:	1700 East Ash Street Suite 201 Goldsboro NC 27863	ooro NC 27863	Provi	Provider # MHL	- 096-186
Finding	Corrective Action Steps	Steps	Responsible Party	<b>Y</b>	Time Line
V 000 INTITIAL COMMENTS V 000 An annual and follow up survey was completed on November 28, 2018. A deficiency was	To comply with required ratio of 50:1, caseloads will be evenly distributed across the board to not exceed 50 patients by Program Director having additional patients added to current caseload until Counselor #5 returns from Maternity Leave on 1-8-2019.	seloads will be evenly 50 patients by Program to current caseload until ve on 1-8-2019.	Amber Leclercq, Program Director		Implementation Date: 12-3-2018
service category: 10A NCAC 27G .3600, Outpatient Opioid Treatment. The census at the time of the survey was 215. V 235 27G .3603 (A-C) Outpt. Opiod Tx Staff (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof	DHSR - Mental Health  DEC 052018  Lic. & Cert. Section	al Health 118 ection		·6-71	8107-6-21
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- Counselor #5 had no caseload. - The Clinic Director had a caseload of 9	clients.	
	- Counselor #5 had no caseload.	
	- The Chillic Director had a caseload of 9	

clients.		
During interview on 11/27/18 Counselor		
#1 stated she was hired as a counselor in		
August 2018.		
Her caseload of 57 was large and		
sometimes it was "a little tough to stay on		
top of things and keep everything up to date."		
During interview on 11/27/18 Counselor		
#2 stated he had 52 clients on his		
caseload and it was manageable.		
During interviews on 11/27/18 and		
11/28/18 the		
Clinic Director stated Counselor #5 went		
out on maternity leave within 90 days of		
her hire. She		
was not assigned a caseload prior to her		
maternity leave because she had not		
completed her 90 day training period.		
Assigning and reassigning clients to		
counselors was not fair to the clients.	2	
Upon Counselor #5's return she would be		
assigned a caseload.		
This deficiency constitutes a re-cited		
deficiency continued From page 2 V 235		
and must be corrected within 30 days.		

(muhan 5. Techner) 12-3-18.

# STATE FORM: REVISIT REPORT

			OIAIL	OTAM: IXE	HOIT INEL OINT				
	ER / SUPPLIER		NSTRUCTION				DAT	E OF REVISIT	
MHL096		Y <sub>1</sub> B. Wing					<sub>Y2</sub> 11/2	8/2018 <sub>Y3</sub>	
NAME OF FACILITY					STREET ADDRESS, (	CITY, STATE, ZIP C			
CAROLINA TREATMENT CENTER OF GOLD						TREET, SUITE 200, 201, 202 & 300			
					GOLDSBORO, NC 27530				
correctiv	re action was a ation prefix cod	ed by a State surveyor t accomplished. Each de de previously shown on	ficiency should	d be fully ident	ified using either the	regulation or LSC	C provision num	ber and the	
ITE	M	DATE	ITEM		DATE	ITEM		DATE	
Y4		Y5	Y4		Y5	Y4		Y5	
ID Prefix	V0118	Correction	ID Prefix V0	0238	Correction	ID Prefix		Correction	
Reg.#	27G .0209 (C)	Completed	Reg. # 270	G .3604 (E-K)	Completed	Reg. #		Completed	
LSC		11/28/2018	LSC		11/28/2018	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC		•	LSC		•	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg.#		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC			LSC		_ `	
D Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
_SC			LSC			LSC		_	
				V					
D Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
SC			LSC			LSC		_	
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATUR	e Of SURVEYOR	Both Phil	Deys MARC	11/28/18	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE	Facility Compliance	e Consultant I	DATE		
FOLLOWUP TO SURVEY COMPLETED ON 9/21/2017			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO						

Page 1 of 1

EVENT ID:

LZFW12



ROY COOPER · Governor

MANDY COHEN, MD, MPH . Secretary

MARK PAYNE • Director, Division of Health Service Regulation

November 29, 2018

Amber Leclercq, Clinic Director ATS of North Carolina, LLC 1700 East Ash Street, Suite 201 Goldsboro, NC 27530

Re:

Annual and Follow-Up Survey completed 11/28/18

Carolina Treatment Center of Goldsboro

MHL # 096-186

E-mail Address: Amber.Sasser@ctcprograms.com; David.Cassise@ctcprograms.com

Dear Ms. Leclerca:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed November 28, 2018.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report.

Enclosed you will find the deficiency cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiency found, the time frame for compliance plus what to include in the Plan of Correction.

# Type of Deficiencies Found

Re-cited standard level deficiency.

## **Time Frames for Compliance**

 Re-cited standard level deficiency must be corrected within 30 days from the exit of the survey, which is December 28, 2018.

## What to include in the Plan of Correction

- Indicate what measures will be put in place to *correct* the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.

Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the <u>original</u> completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Wendy Boone, South Coastal Team Leader, at 252-568-2744.

Sincerely,

Connie Anderson

Comie andum

Both Philless, MARd

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Beth Phillips

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Cc: Sarah Stroud, Director, Eastpointe LME/MCO

Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO

File