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V 000	INITIAL COMMENTS An annual and complaint survey was completed on December 5, 2018. The complaint was substantiated (intake #NC00144817). Deficiencies were 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 125.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or	V 118		

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V 118	Continued From page 1 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure medications were only administered on the written order of a person authorized by law to prescribe medications affecting 1 of 13 sampled clients (Client #7). The findings are: Review on 12/3/18 of the record for Client #7 revealed: -admitted on 8/29/18 with diagnoses of Opioid Use Disorder, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Depression, and Anxiety. Review on 12/3/18 of Client #7's Medication Administration Record from September 2018 through November 2018 revealed daily dosing of Methadone as follows: -9/7 to 9/14 - 165 milligrams (mg) -9/15 to 9/16 absent -9/17 to 9/21 - 160 mg -9/22 to 9/28 - 155 mg -9/29 to 10/5 - 150 mg -10/6 to 10/12 - 145 mg -10/13 to 10/19 - 140 mg -10/20 to 10/26 - 135 mg -10/27 to 10/30 - 130 mg Review on 12/4/18 of Client #7's Physician Orders from September 2018 through November 2018 revealed:	V 118		

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V 118	Continued From page 2 -no order for the above titration that started on 9/7/18 Interview on 12/5/18 with the Licensed Practical Nurse revealed: -she could not locate the physician's orders for the titration of Client #7's Methadone -she remembered it being in the client's electronic record at the time and thought it may have been inadvertently deleted by the physician.	V 118		
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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to access the North Carolina Health Care Personnel Registry (HCPR) prior to hire in order to ensure each staff member had no substantiated findings listed for 2 of 3 sampled staff (Counselor #1 and Counselor #2). The findings are: Review on 12/5/18 of the personnel records for Counselor #1 and Counselor #2 revealed: -Counselor #1 was hired 6/19/18	V 131		

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V 131	Continued From page 3 -Counselor #2 was hired 11/16/17 -neither file contained documentation that the required HCPR checks had been done prior to hire and that the results verified no substantiated findings. Interview on 12/5/18 with the former Program Director assisting the surveyor's revealed: -these documents might have been on file in the corporate office -she was unable to locate the HCPR checks prior to exit.	V 131		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 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 continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV,	V 235		

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V 235	Continued From page 4 sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure all staff received continuing education to include understanding of the nature of addiction, withdrawal syndrome, group and family therapy, and infectious diseases for 3 of 3 sampled staff, the Licensed Practical Nurse (LPN), Counselor #1 (C#1) and Counselor #2 (C#2). The findings are: Review on 12/5/18 of the personnel records for the LPN, C#1 and C#2 revealed: -none of the documentation demonstrated training in the nature of addiction, withdrawal syndrome, group and family therapy, and infectious diseases. Interview on 12/5/18 with C#1, C #2 and the LPN revealed: -they could not recall having had training specifically in the above areas. Interview on 12/5/18 with the former Program Director assisting the surveyor's revealed: -these documents may be filed in the corporate office -she was unable to locate the above training's prior to exit.	V 235		
V 238	27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program	V 238		

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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 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

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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 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

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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 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

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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 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

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V 238	Continued From page 9 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 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 upon record reviews and interviews the facility failed to ensure that during the first year of continuous treatment each client attended a	V 238		

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minimum of two counseling sessions per month for 6 of 13 sampled clients (Clients #2, #7, #8, #9, #10 and #11) and after the first year of treatment attended at least one counseling session per month for 1 of 13 sampled clients (Client #3). The facility also failed to ensure at least one random drug test was conducted on each client per month affecting 2 of 13 sampled clients (Clients #5 and #7). The findings are:

Findings #1:

Review on 12/3/18 of the record for Client #2 revealed:
-admitted on 5/26/18 with a diagnosis of Opioid Use Disorder, Severe.
-there were not 2 required counseling sessions documented from Counselor #1 (C #1) for September, October or November 2018.
-a case note signed by C #1 documented, "Patient came in for scheduled counseling session. Due to having to fulfill receptionist duties unable to meet pursuant to OTP requirements."

Review on 12/3/18 of Client #2's Medication Administration Record revealed:
-in September he was present and dosed 21 days at the clinic
-in October he was present and dosed 18 days at the clinic.

Interview with C#1 on 12/5/18 revealed:
-during the illness and subsequent absence of one of the staff members she was required to provide receptionist duties for the facility.
-these duties alternated with Counselor #2 (C#2) and her clinical supervisor told her to document the cause for missed sessions.

Review on 12/3/18 of the record for Client #3

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revealed:
-admitted on 4/12/17 with a diagnosis of Opioid Use Disorder.
-the client was required one counseling session per month.
-there was no documented counseling session held in September 2018.

Interview with Counselor #3 (C #3) on 12/4/18 revealed:
-he had been on medical leave for the period of the missed session.
-other counseling staff had attempted to cover for his caseload responsibilities but were unable to see this client in September.

Review on 12/3/18 of the record for Client #7 revealed:
-admitted on 8/29/18 with diagnoses of Opioid Use Disorder, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Depression, and Anxiety.
-there was no second counseling session documented in August 2018
-no documented sessions in September 2018
-a note dated 9/26/18 by C #1 documented she was unable to fulfill counseling requirements due to receptionist duties
-there was no second counseling session documented in November 2018.

Review on 12/3/18 of the record for Client #8 revealed:
-admitted on 8/17/18 with a diagnosis of Opioid Use Disorder.
-no second counseling sessions were held in August, September, or October 2018
-no counseling sessions were held in November 2018
-a note dated 11/30/18 by C #1 documented she

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V 238	Continued From page 12 was unable to fulfill counseling requirements due to receptionist duties. Review on 12/4/18 of the record for Client #9 revealed: -admitted on 8/24/18 with a diagnosis of Opioid Use Disorder -no counseling sessions documented for October 2018 -no second counseling session documented in November 2018. Review on 12/4/18 of the record for Client #10 revealed: -admitted on 8/17/18 with a diagnosis of Opioid Use Disorder -no second counseling session documented in October 2018 -a note dated 10/15/18 by C #1 documented she was unable to fulfill counseling requirements due to receptionist duties. Review on 12/4/18 of the record for Client #11 revealed: -admitted on 1/3/18 with a diagnosis of Opioid Use Disorder -no second counseling session documented in October 2018 Findings #2: Review on 12/4/18 of the record for Client #5 revealed: -admitted on 3/2/18 with a diagnosis of Opioid Use Disorder. -no September 2018 result for the required monthly drug test was in the client record. Review on 12/3/18 of the record for Client #7 revealed:	V 238		

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V 238	Continued From page 13 -no September 2018 drug test result was in the client record. Interview on 12/5/18 with the LPN and the former Program Director assisting the surveyor's revealed: -the facility did not have results of screens during a three week period in September 2018 -this was due to the sale of the Program to a new licensee and the resulting decision to use a different laboratory -there was a delay in getting a contract and supplies to submit screens from the new laboratory company.	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,	V 536		

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	MHL022-017	A. BUILDING: _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 536	Continued From page 14 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	V 536		

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V 536	Continued From page 15 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	V 536		

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V 536	Continued From page 16 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 review and interview, the facility failed to ensure all staff including service providers, completed training in alternatives to restrictive interventions from an approved curriculum annually for 3 of 3 sampled staff, the	V 536		

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V 536	Continued From page 17 Licensed Practical Nurse (LPN), Counselor #1 (C#1) and Counselor #2 (C#2). The findings are: Review on 12/5/18 of the personnel records for the LPN, C#1 and C#2 revealed: -none of the documentation demonstrated the staff had completed training in alternatives to restrictive interventions -neither counselor was fully licensed. Interview on 12/5/18 with C#1 revealed: -she could not recall having had training specifically in techniques of how to deescalate client behavior as an alternative to more restrictive interventions. -the facility did not use physical restraints and she had not observed any staff attempting to physically restrain a client. Interview on 12/5/18 with C#2 revealed: -she had not had any training in alternatives to restrictive interventions. -she felt she was learning these techniques as a part of graduate study outside the facility.	V 536		