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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 12/12/18. The complaint intake #NC00144367 was substantiated and the complaint intake #NC00145124 was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A 27G .3600 Outpatient Methadone. The current census is 200 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. (f) The governing body for each facility shall	V 109		

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V 109	Continued From page 1 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 record reviews and interviews, 2 of 2 former staff (the former Registered Nurse (FRN) & the former Clinic Director (FCD)) failed to demonstrate knowledge skills and abilities required by the population served. The findings are: Finding #1: FRN medication errors and methadone spill error: Review on 12/5/18 and 12/6/18 of FRN's record revealed: - Hire date: 5/16/18 - Termination date: 10/29/2018 - An "Employee Improvement Plan (EIP)" form dated 10/15/18 noted: a written warning was issued due to "Not bringing patients doses down after missing days according to standing orders and increasing doses when a patient misses a day after coming down for missing. [Client #8] 10/01/2018, [client #9] 10/13/2018, [client #10] 10/6/2018." - An EIP dated 10/29/18 noted: a final warning and termination due to "Dosing [client #11] under [client #12] chart and giving pt (patient) 5mg less then Medically ordered by the Physician and editing dosing history to show no error. Pouring	V 109		

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Methadone down the drain. Signing to correct the error that was made.
Current Situation (Outline reason(s) for this EIP): Endangering patients and falsifying records and inventory not being accurate ..."

Review on 12/6/18 of the "Standing Orders" for methadone treatment revealed:
- "Missed Days: For Methadone: ... For Established Patients Only:
  - Absent 1 day: May resume at usual dose
  - Absent 2 days: Reduce dose to 75% and return to full dose the next day
  - Absent 3-4 days: Do a COWS (Clinical Opioid Withdrawal Scale), UDS (urine drug screen) and determine last drug use. If COWS >8 patient may dose at 50% on the first day back, 75% the second day back, Resume regular dose on the third day. If COWS <8, call MD (medical doctor/medical director) before dosing again ..."

Review on 12/6/18 of the facility's incident reports revealed:
- An incident report for client #8 dated 10/1/18 that noted: "Nurse (the FRN) was suppose to deducte dose to 53 mg for absent of 2 days. Nurse dosed patient at 70mg. MD (Medical Director) notified of medication error."
- An incident report for client #9 dated 10/13/18 that noted: "[Client #9] was absent for two days. Standing written orders to decrease to 75% of dose. Pt (patient) was due to dose at 41 mg. [The FRN] dosed patient at 55 mg. MD notified."
- An incident report for client #10 dated 10/6/18 that noted: "[Client #10] missed two days and came down to 90 mgs on 10/1/18. Pt missed 10/5/18 and was to remain @ 90mg on 10/6/18 until she dosed two consecutive days to increase to normal dose of 120mg. [The FRN] increased the patient on 10/6/18 to 120mg. MD notified."

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- There was not an incident report for a medication error on 10/29/18 in which client #11 was administered client #12's dose of methadone;
- There was not an incident report related to the spill of methadone by the FRN on 10/29/18.

Review on 12/6/18 of client #8's record revealed:
- An admission date of 6/9/18
- A diagnosis of Opioid Use Disorder, Severe
- A physician's order for methadone 70 mg dated 8/28/18;
- The "Dose History Report" dated 9/1/18 to 12/6/18 revealed:
    - Methadone was administered at a dose of 70 mg from 9/1/18 to 9/28/18, other than one AWOL (absent without leave) on 9/8/18;
    - Client #8 was AWOL for dosing two days in a row on 9/29/18 and 9/30/18;
    - Methadone 70 mg was administered by the FRN on 10/1/18 rather than the 75% dose (53mg) required by standing orders for 2 missed days;
- A nursing note dated 10/1/2018 that noted: "Pt was missed dosed today. She was suppose to be given 53 mg and the Nurse (the FRN) gave her 70 mg. When a patient missed 2 days they decrease to 75% of their dose. MD notified."

Review on 12/6/18 of client #9's record revealed:
- An admission date of 6/6/18
- A diagnosis of Opioid Use Disorder, Severe
- A physician's order for methadone 55mg per day dated 7/24/18, with a decrease to 28 mg per day on 10/6/18 due to "missed 3 days";
- Client #9's ordered dose of methadone was adjusted due to AWOL from 55 mg to 28 mg on 10/6/18 for 3 consecutive missed doses, then incrementally increased back to 55 mg on 10/10/18;
- The "Dose History Report" dated 9/1/18 to

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V 109	Continued From page 4 12/6/18 revealed: - Client #9 was administered 55 mg of methadone on 10/10/18; - Client #9 was AWOL on 2 consecutive days on 10/11/18 and 10/12/18; - Methadone 55 mg was administered by the FRN on 10/13/18 rather than the 75% dose (41 mg) required by standing orders for 2 missed days. Reviews on 12/6/18 and 12/11/18 of client #10's record revealed: - An admission date of 6/8/18 - A diagnosis of Opioid Use Disorder, Severe - A physician's order for methadone 120mg dated 8/27/18, with a decrease to "patient dosing at 75% (90mg) due to absence"; - The "Dose History Report" dated 10/1/18 to 12/9/18 revealed: - Client #10 was AWOL for two consecutive days on 10/2/18 and 10/3/18; - Client #10 was dosed correctly at 90mg on 10/4/18; - Client #10 was AWOL on 10/5/18; - Methadone 120mg was administered by the FRN on 10/6/18 rather than remaining at the reduced dose required by standing orders due to missed days; - A Nursing note dated 10/6/18 revealed: "Patient was suppose to remain at 90mg for missing days. Nurse (the FRN) brought patient back up to 120mg after missing a day of decreasing dose. MD notified." Review on 12/12/18 of client #11's record revealed: - An admission date of 9/2/17; - A diagnosis of Opioid Use Disorder, Severe; - A physician's order for methadone 65mg dated 12/2/17;	V 109		

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- The "Dose History Report" dated 9/1/18 to 12/12/18 revealed:
    - A dose of 60mg of methadone was administered to client #11 by the FRN on 10/29/18 rather than the ordered 65mg;
- No nursing note related to the dose error was present.

Review on 12/12/18 of client #12's record revealed:
- An admission date of 10/11/17;
- A diagnosis of Opioid Use Disorder, Severe
- A physician's order for methadone 60mg dated 12/31/17 (the dose amount that client #11 received) as client #11 was dosed under client #12's record

Attempts to interview clients #8-#12 from 12/5/18-12/12/18 were unsuccessful as they did not respond/consent to interview requests.

Interviews on 12/4/18 and 12/6/18 with the FRN revealed:
- When clients missed 2-3 days of dosing, the protocol was to reduce their dose by 25%;
- The computer software system used by the facility did not have "flags" to let the dosing nurses know when clients' doses needed to be decreased;
- In order to see if a client had been AWOL the previous day, the nurse would need to scroll down the dosing page and search on a different screen in the computer program;
- She preferred a different software system that was used at other methadone clinics over the one used by the facility;
- Following her first EIP on 10/15/18 for the medication errors for client #8 on 10/1/18, for client #10 on 10/6/18 & client #9 on 10/13/18, the FRN started placing "sticky" notes on her

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computer to alert her to which clients had been AWOL on the previous day;
- She could not remember exactly what happened to result in the additional medication error in which client #11 was administered client #12's methadone dose on 10/29/18;
- She had reported her concerns about the computer software system to the FCD, but "[the FCD] wasn't there every day and when you took problems to her, they wouldn't be addressed ..."
- She could not remember exactly what happened when she had also spilled methadone on 10/29/18;
- She had "panicked and dumped it (the methadone) down the drain ..."
- She thought she had possibly spilled 60 milliliters of methadone;
- The facility's policy regarding methadone spills was to tell management and complete an incident report;
- The spill was not related to diversion of methadone, and there had not been any concerns about methadone diversion at the facility;
- She had resigned from her position on 10/29/18.

Interview on 12/5/18 the MD revealed:
- If a client missed one day, no changes were made to the dose and they resumed the previous dose upon their return;
- If a client missed two days, their dose was decreased by 25%, and they could return to the previous dose if they returned the next day;
- Every client had standing orders in place to address AWOL/missed days, and the standing orders specified the dose that should be administered.

Interview on 12/10/18 with the FCD revealed:
- She had been the Clinic Director until 11/30/18;

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V 109	Continued From page 7 - When the FRN had made the medication errors with clients #8-11, incident reports were completed and the MD was notified; - Clients #8-11 did not experience any negative health outcomes from the medication errors; - The facility's computer software system did have "flags" to notify nurses of clients' AWOLs, but the flags were " ... so small you can barely see it ... In my opinion, it could lead to dosing errors ..." - The facility was a pilot program for the computer software system; - The FRN had also spilled methadone on 10/29/18, but had not followed the facility's protocol to report the incident; - A Drug Enforcement Agency audit had recently been completed at the facility, and there were no concerns about diversion of methadone; - The FRN was terminated from employment due to the multiple medication errors and methadone spill. Interviews on 12/3/18 and 12/6/18 with the Clinic Director revealed: - She had to search through a stack of records left by the FCD to find the FRN's employee record; - She had first learned of the FRN's medication errors and methadone spill when she found the FRN's employee record; - She was not aware of any negative outcomes for clients who had medication errors; - There had not been any concerns about diversion of methadone at the clinic that she was aware of; - The FRN had not followed the facility's standing orders for AWOLs or for methadone spills. Finding #2: FCD responsibilities not fulfilled:	V 109		

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V 109	Continued From page 8 Review on 12/6/18 of Counselor #1's employee record revealed: - Hire date of 8/7/17 as a Counselor I; - No documentation of highest degree earned; - Documentation of registration as a CSAC-R (Certified Substance Abuse Counselor-Registered); - No documentation of training in drug abuse withdrawal symptoms, symptoms of secondary complications to drug addiction, nature of addiction, the withdrawal syndrome, or group and family therapy. Review on 12/5/18 of Counselor #2's employee record revealed: - Hire date of 2/21/18 as a Counselor I; - Highest degree earned was an Associate of Applied Business; - Documentation of registration as a CSAC-R; - No documentation of training in drug abuse withdrawal symptoms; symptoms of secondary complications to drug addiction, nature of addiction, the withdrawal syndrome, group and family therapy, or Infectious Diseases including HIV (human immunodeficiency virus), STDs (sexually transmitted diseases) and TB (tuberculosis). Review on 12/5/18 of Counselor #3's employee record revealed: - Hire date on 6/1/18 as a Counselor I; - No documentation of highest degree earned; - Documentation of registration as a CSAC; - No documentation of training in drug abuse withdrawal symptoms, symptoms of secondary complications to drug addiction, nature of addiction, the withdrawal syndrome, group and family therapy, or Infectious Diseases including HIV, STDs and TB.	V 109		

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V 109	Continued From page 9 Review on 12/6/18 of the FCD's employee record revealed: - Hire date of 6/3/17; - Termination date of 11/16/2018; - Documentation of registration as a Licensed Clinical Addiction Specialist (LCAS); - A job description for the position of Clinic Director, signed by the FCD on 5/16/17; - The job description responsibilities included: " ... The Clinic Director is responsible for providing training and supervision of all staff ... The Clinic Director is responsible for the security of medications, patient records, employee records and any other documentation deemed necessary by the Clinic Sponsor, the FDA (Food Drug Administration), DEA (Drug Enforcement Agency) and/or State ADP (treatment program regulatory agency) ..." - An additional form titled: "Clinic Director CTC (comprehensive treatment center) Job Description" that was missing pages 3 and 4 of 4 pages was present in the record and noted "Essential Functions" of the position that included: - " ... Accountable for managing people, setting direction and deploying resources; typically is responsible for performance evaluations, pay reviews and hire/fire decisions; - Responsible for providing training and development opportunities for clinic staff ..." Interview on 12/12/18 with Counselor #1 revealed: - His caseload of 66 clients exceeded the maximum of 50 specified in 10A NCAC 27G .3603 Staff (V235); - The FCD had told him she was working on hiring another counselor in order to reduce his caseload size; - He had completed high school only and did not have any formal substance use disorder training	V 109		

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prior to employment;
- (While reviewing 10A NCAC 27G. 03603 Staff (V235) staff training requirements) He had not received several of the trainings required by rule;
- He had only been introduced to treatment plans "about two months ago;"
- He was told that the way in which he had been taught to complete treatment plans under the direction of the FCD was incorrect;
- He had "already learned more in the last two weeks" under the new Director than he had since he was hired in August of 2017;
- He felt that he was "undertrained", and was excited that the new management at the facility was making changes there.

Interview on 12/6/18 with Counselor #2 revealed:
- He had started working at the facility in February of 2018;
- There were 3 full-time and 1 part-time Counselors at the facility to work with the 200 currently-enrolled clients;
- His caseload was 50 people;
- There was "no real training involved" for the facility's counselors;
- He believed that the facility would begin to "flourish because we have a Director who is going to be present";
- The FCD had not been present at the facility consistently;
- The main issue that he thought needed to be addressed at the facility was staff training.

Interview attempts with Counselor #3 on 12/11/18 and 12/12/18 were unsuccessful due to Counselor #3 being unable to reach the facility due to snow and no answer to attempted telephone calls on 12/12/18.

Interview on 12/10/18 with the FCD revealed:

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V 109	Continued From page 11 - She had been the Director at the facility from the time it opened in May of 2017 until she resigned on 11/30/18 in order to take a job elsewhere; - When asked about the training process for new employees, the FCD responded: "I was in charge ..." - Staff trainings were all done electronically; - There should be training transcripts in a binder for each staff at the facility; - Each staff would have received trainings required by 10A NCAC 27G. 03603 Staff (V235) as part of a group Power Point presentation within the past 9 months; - Some of the required trainings might be in the facility's electronic staff training program; - She had not provided clinical supervision to Counselors at the facility, rather, she had relied on an outside contract substance use professional to provide clinical supervision to facility counselors; - Treatment plans for clients had initially been completed on the facility's computer software program, but was changed to a PCP (Person Centered Plan) form after the facility started taking Medicaid; - The PCP form had to be scanned manually into the facility's computer software system, and each page took approximately 5 minutes to scan; - Copies of clients' PCPs could be found in a file room at the facility; - After the facility lost their Medicaid funding, they reverted back to the treatment plan format in the computer software system; - The only issue that she was aware of with treatment plans was that a former Counselor had not been completing them after the facility first opened; - Treatment plans were being completed in recent months.	V 109		

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V 109	Continued From page 12 Interviews on 12/3/18 & 12/12/18 with the current Clinic Director (CD) revealed: - She had only been in the position of CD for two weeks; - The position of the CD was responsible for the day to day operations of the facility, staffing, oversight of staff training, and ensuring client records were complete; - She had been told by facility Counselors that the FCD had told them not to do treatment plans and that another staff would complete them for all facility clients; - She was not certain who the staff was that was supposed to be completing treatment plans for all clients; - Even though facility Counselors had been told not to do treatment plans, they had tried to do them on their own; - Facility Counselors had been receiving clinical supervision from an outside contract substance use clinician, but it did not appear that staff had received required trainings; - The CD would ensure staff received required trainings; - The CD would be providing clinical supervision directly to the facility's Counselors rather than use an outside substance use counselor. Interview on 12/12/18 with the Regional Director (RD) revealed: - He had assumed the position of RD approximately two weeks ago at the same time the CD assumed her role; - He had been "blindsided" by the extent of the issues that would need to be addressed at the facility, such as employee trainings; - He did not believe that the former RD, whose position he assumed, had been aware of the issues at the facility; - The facility had been getting "good reports" from	V 109		

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V 109	Continued From page 13 oversight agencies; - He did not know what had happened with the FCD that resulted in the facility having multiple deficient practice areas. This deficiency is cross referenced into 10A NCAC 27G .3601 Scope (V233) for a Type B rule violation and must be corrected within 45 days.	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; (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		

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V 112	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a plan based on the assessment and in partnership with the client or legally responsible person or both within 30 days of admission for clients who were expected to receive services beyond 30 days affecting 3 of 15 audited clients (#8, #9 and #10). The findings are: Review on 12/12/18 of client #8's record revealed: - An admission date of 6/9/18 - A diagnosis of Opioid Use Disorder (D/O), Severe - No evidence of a treatment plan in client #8's record Review on 12/6/18 of client #9's record revealed: - An admission date of 6/6/18 - A diagnosis of Opioid Use D/O, Severe - A treatment plan dated 7/6/18; however, there was no evidence client #9 had signed the treatment plan indicating his written consent or agreement with the treatment plan - The statement "Patient Has Actively Participated in Treatment Plan Process and Agree That It Meets Their Needs" was listed on the treatment plan. A check box next to this statement was left blank - The statement "Patient given a copy? Yes or No" was checked "No." Review on 12/6/18 of client #10's record revealed: - An admission date of 6/8/18 - A diagnosis of Opioid Use D/O, Severe	V 112		

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V 112	Continued From page 15 - No evidence of a treatment plan in client #10's record Interview on 12/12/18 Counselor #1 revealed: - He had attempted to complete treatment plans on behalf of his clients; however, the new Clinic Director had just recently told him that the way he had been completing the treatment plans was incorrect - The new Clinic Director had shown him the correct way of how to complete a treatment plan. Interview on 12/13/18 with the Clinic Director revealed: - Counseling staff had informed her that the previous Clinic Director had instructed the counselors not to complete treatment plans on behalf of their clients and that another counselor would be doing them instead - Although, the counselors had been told this, they still attempted to complete treatment plans themselves - She had been working with the counselors to ensure they understood how and when treatment plans were to be completed. This deficiency is cross referenced into 10A NCAC 27G .3601 Scope (V233) for a Type B rule violation and must be corrected within 45 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number;	V 113		

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V 113	Continued From page 16 (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 113		

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V 113	Continued From page 17 facility failed to ensure a signed statement from the client granting permission to seek emergency care from a hospital or physician was present in 12 of 12 audited current clients' records (#1-12) and 2 of 2 former clients' (FC) records (FC #13 & 14). The findings are: Reviews from 12/3/18 to 12/12/18 of clients' #1-12 and FC #13 and FC #14's records revealed: - No signed consents for emergency care were present. Interview on 12/6/18 with the Front Office Staff revealed: - She had searched in the facility's computer software system and had not found an emergency care consent for the audited clients: - She did not know where else to look for emergency care consents. Interviews with the Clinic Director on 12/3/18 and 12/12/18 revealed: - She had started working at the facility approximately two weeks ago; - She had already found several issues related to client records that she would be addressing; - She had only just gotten access to the facility's client record computer software system on 12/3/18; - The Front Desk Staff might know where to locate emergency care consents for clients; - There was a file room in the facility full of documents waiting to be scanned; - Emergency care consents might be located in the stacks of papers in the file room; - She would be adapting a release of client information consent form from a sister clinic for use at the facility as an emergency care consent.	V 113		

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V 233	Continued From page 18	V 233		
V 233	27G .3601 Outpt. Opiod Tx. - Scope 10A NCAC 27G .3601 SCOPE (a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. (b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual. (c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing doses for a period not to exceed 180 days. (d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide services in a manner designed to offer the individual an opportunity to effect constructive changes in their lifestyle affecting 12 of 12 audited current clients. The	V 233		

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V 233	Continued From page 19 findings are: Cross Reference: 10A NCAC 27G .0203 (V109) Competencies of Qualified Professionals and Associate Professionals (V109). Based on record reviews and interviews, 2 of 2 former staff (the former Registered Nurse (FRN) & the former Clinic Director (FCD)) failed to demonstrate knowledge skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0205 (V112) Assessment and Treatment/Habilitation or Service Plan Based on record review and interview, there facility failed to develop a plan 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 affecting 3 of 12 audited current clients (#8, #9 and #10). Cross Reference: 10A NCAC 27G .3603 (V235) Staff Based on record review and interview, the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients affecting 2 of 3 audited counseling staff (Counselors #1 and #2) and that direct care staff had received continuing education to include understanding of the following: nature of addiction; the withdrawal syndrome; group and family therapy and infection diseases, including HIV (Human Immunodeficiency Virus), sexually transmitted diseases and TB (Tuberculosis) affecting 4 of 5 audited staff (Former Registered Nurse, Counselors #1 and #2 and #3). Review on 12/12/18 of a Plan of Protection	V 233		

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V 233	Continued From page 20	V 233		

completed by the Clinical Director and dated 12/12/18 revealed:
- "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? - All counselors will continue to review their caseloads to ensure updates and completed documents are on file such as but not limited too; treatment plans, assessments, coordination of care, medical plans with clinical medical team and all other requirements set forth for effective comprehensive care. All counselors have been assigned this task the week of state visit and will continue to complete this by week ending 12.21.18. All staff and nursing staff will be included in conducted trainings.
All counselors will begin weekly learning objectives in gaining competencies in the scope of their career details. This will begin with weekly trainings on treatment planning, biopsychosocials/assessment and all other counseling topics for effective treatment planning and completion of assessments. Weekly trainings will be conducted as well as weekly individual counselor check-ins that will detail the above completed documents."
- "Describe your plans to make sure the above happens. A plan of supervision for group as well as individual will begin on 12.17.18 to support the learning and increased counselor competencies for all patient care and documentation to be completed in the time frame required. All caseloads will be reviewed weekly to ensure patient care is priority. Counselors will begin to review concerns with treatment team for further care, protection and prevention. Clinic Director will create plans for training, supervision, opportunities for continued education to increase effectiveness and counseling competencies. Counselor will continue to complete corporate

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V 233	Continued From page 21 trainings through HealthStream. All staff and nursing staff will be included in group and individual trainings and supervisions as required." The facility was licensed to provide outpatient opioid treatment through opioid maintenance medications and counseling to individuals with a long-term history of addiction to opiates. The facility's former Clinic Director failed to fulfill all of the responsibilities of her position as she did not ensure counselors' caseloads did not exceed the maximum of 50 clients per counselor; counselors were completing treatment plans in partnership with their clients on a consistent basis and that counselors had completed the training necessary to assist them in addressing the needs of the facility's clientele. The facility's former Registered Nurse failed to follow the facility's established dosing procedures which led to multiple dosing errors and her failure to follow the proper protocol to address a methadone spillage ultimately led to her termination. This demonstration of a lack of competency on behalf of the former Clinic Director and the Registered Nurse in these areas of client care and services was detrimental to the health and well-being of the clients being served. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 233		
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	V 235		

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V 235	Continued From page 22 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, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on staff of the facility affecting 2 of 3 audited counseling staff (Counselors #1 and #2) and the facility failed to ensure direct care staff received continuing education to include understanding of the following: drug abuse withdrawal symptoms; symptoms of secondary complications to drug addiction; nature of addiction; the withdrawal syndrome; group and family therapy and infectious diseases, including HIV (Human Immunodeficiency Virus), sexually transmitted diseases and TB (Tuberculosis)	V 235		

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V 235	Continued From page 23	V 235		

affecting 4 of 5 audited staff (Former Registered Nurse, Counselors #1, #2 and #3). The findings are:

Finding #1:

Review on 12/3/18 of the facility's Numerical List of Active Patients as of 12/3/18 revealed:
- Counselor #1's caseload consisted of 60 clients
- Counselor #2's caseload consisted of 56 clients

Review on 12/6/18 of Counselor #1's record revealed:
- A hire date of 8/7/17 as a Counselor I

Interview on 12/12/18 with Counselor #1 revealed:
- His current caseload was 66
- He had spoken to the Former Clinic Director (FDC) who stated that she was working to reduce his caseload by hiring another counselor.

Review on 12/5/18 of Counselor #2's record revealed:
- A hire date of 2/21/18 as a Counselor I

Interview on 12/6/18 with Counselor #2 revealed:
- The facility employed three full-time counselors and one part-time counselor
- His current caseload was 50 clients and his caseload was currently "manageable."

Finding #2:

Review on 12/5/18 and 12/6/18 of FRN's record revealed:
- Hire date: 5/16/18
- Termination date: 10/29/2018
- No documentation that FRN had received continuing education to include understanding of

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V 235	Continued From page 24 the following: drug abuse withdrawal symptoms; symptoms of secondary complications to drug addiction; the nature of addiction; the withdrawal syndrome; group and family therapy and infectious diseases, including HIV, sexually transmitted diseases and TB Review on 12/6/18 of Counselor #1's record revealed: - A hire date of 8/7/17 as a Counselor I - Counselor #1 received clinical supervision on at least a monthly basis; however there was no documentation that Counselor #1 had received continuing education in the following: drug abuse withdrawal symptoms; symptoms of secondary complications to drug addiction; the nature of addiction; the withdrawal syndrome; group and family therapy Interview on 12/12/18 with Counselor #1 revealed: - He had completed high school and had no formal substance abuse training prior to his employment at the facility - He had received clinical supervision each month; however, he had not participated in any of the trainings as listed Review on 12/5/18 of Counselor #2's record revealed: - A hire date of 2/21/18 as a Counselor I - Counselor #2 received clinical supervision on at least a monthly basis; however there was no documentation that Counselor #2 had received continuing education in the following: drug abuse withdrawal symptoms; symptoms of secondary complications to drug addiction; the nature of addiction; the withdrawal syndrome; group and family therapy and infectious diseases, including HIV, sexually transmitted diseases and TB	V 235		

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V 235	Continued From page 25 Interview on 12/6/18 with Counselor #2 revealed: - The Former Clinic Director (FCD) was not at the facility on a consistent basis -"There was no real training" involving the counselors. This deficiency is cross referenced into 10A NCAC 27G .3601 Scope (V233) for a Type B rule violation and must be corrected within 45 days.	V 235		
V 237	27G .3604 (A-D) Outpt. Opiod - Operations 10A NCAC 27G .3604 OPERATIONS (a) Hours. Each facility shall operate at least six days per week, 12 months per year. Daily, weekend and holiday medication dispensing hours shall be scheduled to meet the needs of the client. (b) Compliance with The Substance Abuse and Mental Health Services Administration (SAMHSA) or The Center for Substance Abuse Treatment (CSAT) Regulations. Each facility shall be certified by a private non-profit entity or a State agency, that has been approved by the SAMHSA of the United State Department of Health and Human Services and shall be in compliance with all SAMHSA Opioid Drugs in Maintenance and Detoxification Treatment of Opioid Addiction regulations in 42 CFR Part 8, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the CSAT, SAMHSA, Rockwall II, 5600 Fishers Lane, Rockville, Maryland 20857 at no cost. (c) Compliance With DEA Regulations. Each facility shall be currently registered with the Federal Drug Enforcement Administration and shall be in compliance with all Drug Enforcement	V 237		

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V 237	Continued From page 26 Administration regulations pertaining to opioid treatment programs codified in 21 C.F.R., Food and Drugs, Part 1300 to end, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the United States Government Printing Office, Washington, D.C. 20402 at the published rate. (d) Compliance With State Authority Regulations. Each facility shall be approved by the North Carolina State Authority for Opioid Treatment, DMH/DD/SAS, which is the person designated by the Secretary of Health and Human Services to exercise the responsibility and authority within the state for governing the treatment of addiction with an opioid drug, including program approval, for monitoring compliance with the regulations related to scope, staff, and operations, and for monitoring compliance with Section 1923 of P.L. 102-321. The referenced material may be obtained from the Substance Abuse Services Section of DMH/DD/SAS. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that clients were not dually enrolled in other outpatient opioid treatment programs affecting 6 of 12 audited current clients (#2, 3, 6, 8, 9 & 10). The findings are: Reviews from 12/3/18 to 12/12/18 of clients #2, 3, 6, 8, 9 & 10's records revealed: - No documentation of a dual enrollment check. Review on 12/12/18 of a "Dual Enrollment" binder provided by the Clinic Director (CD) revealed: - No documentation of a dual enrollment check for clients #2, 3, 6, 8, 9 & 10.	V 237		

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V 237	Continued From page 27 Interview on 12/6/18 with the Front Office Staff revealed: - Dual enrollment checks were completed by the Medical Director (MD) before each client began receiving services at the facility; - The Front Desk Staff also checked for dual enrollment, but did not print them; - She did not know that dual enrollment checks needed to be printed for inclusion in clients' records. Interview on 12/5/18 the MD revealed: - She checked for dual enrollment for every client when they were seen for their initial history and physical; - The dual enrollment information was printed and should have been scanned into each clients' electronic record. Interview on 12/10/18 with the former Clinic Director (FCD) revealed: - Before she left the facility, dual enrollment checks had been completed for each client; - Copies of the dual enrollment checks were kept in a binder in the front office; - The Front Office Staff knew where the dual enrollment forms were; - Dual enrollment forms had to be manually scanned into the facility's client records computer software program; - She was not sure how Surveyors could confirm that dual enrollment checks had been completed for each client. Interview with the Clinic Director on 12/12/18 revealed: - She did not know why dual enrollment checks were missing for clients #2, 3, 6, 8, 9 & 10; - There was a file room in the facility full of	V 237		

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V 237	Continued From page 28 documents waiting to be scanned; - Dual enrollment documentation might be somewhere in the stacks of papers in the file room; - The facility was currently using a the "Lighthouse" system to check for dual enrollment; - The Lighthouse system would make it easier to ensure dual enrollment was completed.	V 237		
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	V 536		

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V 536	Continued From page 29 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 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;	V 536		

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V 536	Continued From page 30 (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 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	V 536		

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V 536	Continued From page 31	V 536		

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 staff received the initial training in alternatives to restrictive intervention affecting 2 of 5 audited staff (Former Registered Nurse (FRN) and Counselor #3) and the facility failed to ensure staff received annual refresher training in alternatives to restrictive interventions affecting 1 of 5 audited staff (the Former Clinic Director (FCD)). The findings are:

Review on 12/5/18 of Former Registered Nurse's

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V 536	Continued From page 32 (FRN) record revealed: - Hire date: 5/16/18 - Termination date: 10/29/2018 - No documentation that FRN had completed the initial training in alternatives to restrictive intervention Review on 12/5/18 of Counselor #3's employee record revealed: - Hire date on 6/1/18 as a Counselor I - No documentation that Counselor #3 had completed training in alternatives to restrictive intervention Review on 12/6/18 of the Former Clinic Director's (FCD) employee record revealed: - Hire date of 6/3/17 - Termination date of 11/16/18 - The FCD's training in alternatives to restrictive interventions had expired on 2/28/18 - No documentation that the FCD had completed training in alternatives to restrictive interventions since 2/28/18 Interview on 12/10/18 with the FCD revealed: - "We all completed it (training in alternatives to restrictive interventions) again, everybody is up to date on that...I can't remember the exact date." - She provided the name of the individual who conducted the training class she participated in as well as the name of the individual who conducted the training in alternatives to restrictive interventions for the newer staff. Interview on 12/12/18 with the Clinic Director revealed: - She had just begun working at this facility in late November 2018 - She had requested staff provide her with certificates of any training they had participated in	V 536		

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V 536	Continued From page 33 prior to her becoming the new Clinic Director - Going forward, she would schedule the training so that all staff attended the training at the same time each year.	V 536		