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BHG ASHEVILLE TREATMENT CENTER	18 WEDGEFIELD DRIVE ASHEVILLE, NC 28806

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V 000	INITIAL COMMENTS An annual, follow up and complaint survey was completed on February 13, 2019. The complaint was substantiated (#NC00147302). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105		

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V 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on observation, record review and	V 105		

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V 105	Continued From page 2 interviews the facility failed to develop and implement written policies for the adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for Drug Testing and Sample Collection Procedures. The findings are: Observation on 2/11/19 at 9:00AM in the laboratory located directly next to the bathroom used for urine drug screen testing revealed: -Small sink was full of 38 cups of urine specimens that had been collected on that date. -Each cup had a strip seal over the lid that attached to both sides of the cup. -The cups had hand written names of clients. Review on 2/12/19 of the policy titled "Drug Testing and Sample Collection Procedure" dated 7/31/18 revealed: -" ...BHG team members responsible for collecting and submitting samples for UDS (urine drug screens) will be properly trained, and proof of competency will be kept in the employee file ..." -" ...Only BHG team members who have received appropriate training and have a completed Competency Assessment and Quiz are allowed to perform collection of urine samples ..." Review on 2/13/19 of the personnel record for Medical Assistant #1 revealed: -Date of hire was 7/30/18. -Certified Clinical Medical Assistant dated 5/16/18. -Training in Urine Drug Screen collection and procedures was on 1/16/19. No documentation of competency testing. Review on 2/13/19 of the personnel record for Medical Assistant #2 revealed: -Date of hire was 2/7/19.	V 105		

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V 105	Continued From page 3 -No documentation of training or competency testing in Urine Drug screening collection and procedures. Interview on 2/11/19 with Medical Assistant #2 revealed: -It was her third day working in the clinic. -She stated that she called the client back for a urine drug screen and checked their identification card and matched to their date of birth. -After urine was collected she checked the temperature of the urine and placed the seal over the lid. -She did not bag the urine. -She did not properly label the urine because "the labeler was broke". -She stated that all the urine specimens stacked in the sink were collected that morning and would be sent out to the laboratory that afternoon. Interview on 2/12/19 with Medical Assistant #2 revealed: -The proper procedure for urine collection was to collect the specimen, check the urine temperature, verify with the client, seal the cup, label the cup and verify again with the client, and then bag the urine and place into the proper bag for shipping. -Storing urine cups in the sink was not proper procedure. -She had received training for urine collection procedures. -Medical Assistant #1 had worked the weekend and on 2/11/19. She was not trained. -On 2/11/19 Medical Assistant #1 had not been set up on the computer so she could not print labels for the urine specimens. -After dosing hours on 2/11/19 she printed all the labels for the urine specimens at her computer and the specimens were bagged to be shipped.	V 105		

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V 105	Continued From page 4 Interview on 2/12/19 with the Program Director revealed: -Proper procedure for urine collection was to collect urine, label, and seal and bag the urine immediately following collection. The samples were then shipped out to the laboratory. -Medical Assistant #1 could not get into their computer system. She was made aware of the problem and had Medical Assistant #2 help her. -Nursing staff was responsible for training on urine collection and had indicated that the training had been done. -The policy of the clinic was to train staff on the proper procedures for urine drug testing and have staff demonstrate competency prior to conducting the urine drug screens. 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 105		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens.	V 108		

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V 108	Continued From page 5 (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that one staff member was available in the facility at all times that had been trained in cardiopulmonary resuscitation (CPR) effecting 2 of 2 Registered Nurses (RN #1, RN #2). The findings are: Review on 2/11/19 of the personnel record for RN (Registered Nurse) #1 revealed: -Date of hire was 5/30/17. -Current Permanent RN license. -No documentation for current training in CPR. Review on 2/11/19 of the personnel record for RN #2 revealed: -Hired on 7/23/18. -Active Permanent RN license maintained in the record.	V 108		

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V 108	Continued From page 6 -No documentation for current training in CPR. Interview on 2/12/19 with the Program Director revealed: -There policy was to always have a staff member in the building that had been trained in CPR. -She was responsible for keeping track of when training was due. -She was not aware that the CPR for one of the nurses had expired. -The other Nurse was a trainer for CPR but there was no documentation of that in the file. 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 108		
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 review and interview the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 3 of 7 audited	V 131		

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V 131	Continued From page 7 staff (Counselor #2, Medical Assistant #1, Medical Assistant #2). The findings are: Review on 2/11/19 of the personnel record for Counselor #2 revealed: -Hired on 6/11/18. -CSAC-R (Certified Substance Abuse Counselor Registered) as of 4/28/16. -No Health Care Personnel Registry check documented prior to hire. Review on 2/13/19 of the personnel record for Medical Assistant #1 revealed: -Date of hire was 7/30/18. -HCPR check conducted on 7/31/18. Review on 2/13/19 of the personnel record for Medical Assistant #2 revealed: -Date of hire was 2/7/19. -No Health Care Personnel Registry check documented prior to hire. Interview on 2/13/19 with the Director of Regulatory Affairs revealed: -Former program Director was not on site regularly and had failed to ensure that regulatory requirements were met. His employment was terminated on 11/27/18. There was no administrative leadership locally to oversee the former Program Director. -The former Director had no checks and balances in place. -There was a human resources department, however, most of the responsibility for hiring staff fell on the Program Director. They were currently recruiting a new Human Resources Director. She felt that the human resources department needed to be more involved in the process. This deficiency constitutes a re-cited deficiency.	V 131		

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V 131	Continued From page 8 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 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this	V 133		

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V 133	Continued From page 9 section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history	V 133		

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V 133	Continued From page 10	V 133		

record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.

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V 133	Continued From page 11 (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related	V 133		

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V 133	Continued From page 12 offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interview the facility failed to submit the request for a criminal record check within five business days of making the conditional offer of employment for 2 of 7 audited staff (Medical Assistant #1, Medical Assistant #2). The findings are: Review on 2/13/19 of the personnel record for	V 133		

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V 133	Continued From page 13 Medical Assistant #1 revealed: -Date of hire was 7/30/18. -No criminal record check documented. Review on 2/13/19 of the personnel record for Medical Assistant #2 revealed: -Date of hire was 2/7/19. -No criminal record check documented. Interview on 2/13/19 with the Director of Regulatory Affairs revealed: -Former program Director was not on site regularly and had failed to ensure that regulatory requirements were met. His employment was terminated on 11/27/18. There was no administrative leadership locally to oversee the former Program Director. -The former Director had no checks and balances in place. -There was a human resources department, however, most of the responsibility for hiring staff fell on the Program Director. They were currently recruiting a new Human Resources Director. She felt that the human resources department needed to be more involved in the process. This deficiency constitutes a re-cited deficiency. 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 133		
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	V 233		

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V 233	Continued From page 14 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 review and interview, the facility failed to ensure services were designed to effect constructive lifestyle changes by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services affecting 5 of 10 audited clients (#5, #6, #8, #9, and #10). The findings are: Cross Reference: 10A NCAC 27G .3603 Staff (V235). Based on record review and interview the facility failed to maintain a ratio of one certified substance abuse counselor for every 50 clients and failed to ensure 6 of 7 audited staff	V 233		

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V 233	Continued From page 15 (Medical Assistant #1, Medial Assistant #2, Counselor #1, Counselor #2, Registered Nurse #1, Registered Nurse #2) were trained in nature of addiction, the withdrawal syndrome, group and family therapy, and infectious diseases including HIV, sexually transmitted diseases and TB. Cross Reference: 10A NCAC 27G .3604 Operations (V238). Based on record review and interview the facility failed to ensure that the required counseling sessions were provided to 5 of 10 audited clients (#1, #3, #4, #7, and #8). Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on observation, record review and interviews the facility failed to develop and implement written policies for the adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for Drug Testing and Sample Collection Procedures. Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (v108). Based on record review and interview the facility failed to ensure that one staff member was available in the facility at all times that had been trained in cardiopulmonary resuscitation effecting 2 of 2 audited staff (RN #1, RN #2). Cross Reference: G.S. 131E-25G Health Care Personnel Registry (V131). Based on record review and interview the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 3 of 7 audited staff (Counselor #2, Medical Assistant #1, Medical Assistant #2). Cross Reference: G.S. 122C-80 Criminal Record	V 233		

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V 233	Continued From page 16 History Check (V133). Based on record review and interview the facility failed to submit the request for a criminal record check within five business days of making the conditional offer of employment for 2 of 7 audited staff (Medical Assistant #1, Medical Assistant #2). Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536). Based on record review and interviews the facility failed to ensure staff had been trained in alternatives to restrictive interventions prior to providing services effecting 5 of 7 audited staff (Counselor #1, Counselor #2, Registered Nurse #2, Medical Assistant #1, and Medical Assistant #2). Cross Reference: 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Based on observation and interviews the facility failed to maintain a safe, clean, attractive and orderly facility. Record review on 2/12/19 for Client #5 revealed: -Admitted on 5/9/17 with diagnoses of Substance Abuse Disorder and Hypothyroidism. -Documentation in the record indicated that Client #5 was prescribed Synthroid (hypothyroidism). -No coordination of care was documented with the prescribing physician and no documentation to indicate the Medical Director reviewed and approved the medications prescribed. Record review on 2/12/19 for Client #6 revealed: -Admitted on 6/24/14 with diagnosis of Opioid Use Disorder. -Medications documented as prescribed by two different physicians for Client #6 were Albuterol (asthma), Flovent (asthma), Omeprazole (acid	V 233		

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reflux), Promethazine (nausea), Viagra (erectile dysfunction), Gabapentin (nerve pain/anticonvulsant), aspirin, Citalopram (depression), Bupropion (depression), and Mirtazapine (depression).
-Release of Information signed on 2/15/18 by Client #6 for a prescribing physician. However, there was no documentation to indicate any follow up coordination of care.
-No documentation to indicate the Medical Director reviewed and approved the medications prescribed.

Record review on 2/12/19 for Client #8 revealed:
-Admitted on 2/21/17 with diagnoses of Opioid Dependence and Schizophrenia.
-Medications documented as prescribed by a local health care provider were Zyprexa (anti-psychotic), Invega (anti-psychotic), Trazodone (depression sleep), Simvastatin (cholesterol), Metformin (diabetes), and Neurontin (anticonvulsant/anti-epileptic).
-Information had been obtained about prescribed medications in 2017. This information was not updated when changes with medications occurred.
-There was no current documentation of coordination of care with the prescribing physician.
-No documentation to indicate the Medical Director reviewed and approved the medications prescribed.

Record review on 2/12/19 for Client #9 revealed:
-Admitted on 1/14/16 with diagnosis of Opioid Dependence.
-There was no documentation in the record that Client #9 took Lovenox (blood thinner) .
-There was no current documentation of coordination of care with the prescribing

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V 233	Continued From page 18 physician. -No documentation to indicate the Medical Director reviewed and approved the medication prescribed. Record review on 2/12/19 for Client #10 revealed: -Admitted on 8/1/16 with diagnosis of Opioid Dependence. -Medication documented as prescribed by a local health care provider was Gabapentin (nerve pain/anticonvulsant) 300mg, 4 tablets three times daily. -There was no current documentation of coordination of care with the prescribing physician. -No documentation to indicate the Medical Director reviewed and approved the medications prescribed. Interview on 2/12/19 with Client #9 revealed: -She stated that she took Lovenox (blood thinner) due to blood clots in her left leg. She did not know if the clinic was aware she took that medication. -She met with the Medical Director twice per year. -Since her admission she had seen multiple counselors. Interview on 2/11/19 with Counselor #1 revealed: -Counselors sent the release of information that had been signed by the client to the prescribing physician. Counselors were also responsible to ensure that information was received by that physician. -One of the nurses or the doctor followed up on any medications. Interview on 2/11/19 and 2/12/19 with Counselor #2 revealed: -Counselors were responsible for coordination of	V 233		

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V 233	Continued From page 19 care with the community dentist and the primary care physician's. He documented all coordination of care efforts in the electronic record. -He had communicated with the adult care home where Client #8 lived about his Methadone, recent behaviors and transportation. He had not had any recent communication or coordination with the mental health provider about his medications. Interview on 2/12/19 with the Program Director revealed: - List of medications given at intake on client's 1st day. They sign a consent for release-counselors follow up with mental health issues and nurses follow up with medical care. -A Nurse or medical assistant sent the release of information to the prescribing physician. -Nursing staff would confirm with the prescriber about medications taken by a client. -The medication log would be completed in the record and reviewed by the Medical Director. The Medical Director should review, make and document any recommendations. -She was not sure if the medication log was used. -Coordination of care "was haphazard at best." This deficiency constitutes a re-cited deficiency. Review on 2/13/19 of the Plan of Protection signed and dated on 2/13/19 by the Director of Regulatory Affairs and the Program Director revealed: "Please find following the Plan of Protection for the identified deficiencies during the State visit to the clinic on February 11 and 12, 2019. Primary responsibility for carrying out all action items will lie with the Program Director, [name]. Support and monitoring will be provided by the Regional	V 233		

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V 233	Continued From page 20 Director, [name], and the BHG Director of Regulatory Affairs, [name]. -Coordination of care: A team-member training will be completed on or before Friday, February 15, 2019. Topics to be covered will include processes for ensuring coordination of care, using BHG policies and procedures to guide the training. The BHG Prescription-OTC Log, the BHG Consent for Release of Prescription Information, and the BHG Release of Information document will all be completed for all patients who are receiving medication from providers outside the BHG system. The primary counseling and nursing team are responsible to ensure these documents are completed and sent to the appropriate providers. All Prescription-OTC Logs will be reviewed and signed by the Medical Director, and this will be facilitated by the Program Director. Patient education regarding the need to bring in any outside medications will be provided via informational flyers in patient areas, in counseling offices, and through discussions with nursing and counseling staff. The Program Director will be ultimately responsible for oversight of the processes and will review this in the weekly treatment team meeting. If we are provided with the names of the five patients who did not have documentation of coordination of care in their file, we will ensure their medications are appropriately addressed using the above process. -Caseloads: There are two new counselors who were hired in the first week of February 2019. Both are currently awaiting licensure, and this is anticipated to occur within the next 30 days. Once this occurs, caseloads will be shifted so that all counselors are in compliance with the client-to-patient ratios. The Program Director is available to assist with overload, particularly if there are crisis situations. The clinic is not	V 233		

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V 233	Continued From page 21 currently doing any intakes to prevent further deficiencies in the client-to-patient ratios. -Training: All team members who are missing any required State and/or BHG trainings will be up-to-date by February 22, 2019. The Director of Regulatory Affairs will be responsible for creating a training specific to Group and Family Therapy, and this will be published to the field on or before February 21, 2019. -Missed counseling sessions: A team-member training will be completed on or before Friday, February 15, 2019. BHG policies and procedures related to counseling will be used to guide the training. Counselors will be instructed to contact patients who miss appointments and utilize the Hold function in the electronic health record to ensure patients are seen at the next subsequent clinic visit. Counselors will use the No-Show Follow-Up service note in the electronic health record to document any discussions or details regarding the missed appointment. The counseling staff will be provided with a tickler template, and this will be utilized for scheduling patients. The Program Director and/or the Regional Director will utilize the BHG Compliance Audit Report to review frequency of counseling visits for each patient - this will occur weekly. The counseling team will continue to perform monthly chart audits as well, which identifies deficiencies, and this will be monitored by the Program Director. If we are provided with the name of the five patients who were found to be missing visits, appropriate follow-up will be completed. -Healthcare personnel registry: When notified of the names of the two team members missing the HPR results, the Program Director will perform the online registry check. Documentation of the check will be housed in the employee files. Moving forward, this will be done on an annual	V 233		

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V 233	Continued From page 22	V 233		

basis. The Program Director will also utilize the BHG HR File Audit Checklist on a quarterly basis, as per BHG policy, and the HPR information will be included on the audit checklist. For new hires, the HPR check will be completed by the Program Director prior to hire.
-Criminal records check: The two team members missing the SBI results will have their fingerprinting performed by the end of the day on Monday, February 18, 2019. The corporate team is working on adding the NC-specific background check requirements to the onboarding process. At the local level, until corporate-level changes are made, the Program Director will be responsible for ensuring all new hires have the SBI background check results prior to their first day of employment.
-Governing body policies - Failure to implement policy (UA procedures in laboratory): The team member who failed to follow policy has been off work ill since the day of the incident. Upon her return, the team member will receive verbal disciplinary action and will be provided with a review of processes and policies related to urine collection procedures. This same review will occur with the entire nursing/medical team. The Program Director will ensure that all role-specific competencies are completed at the time of hire (prior to the performance of any duties) and on an annual basis. Additionally, the Director of Regulatory Affairs and the Program Director will directly observe each member of the nursing/medical team perform urine collection and processing procedures on or before Thursday, February 14th, 2019.
-Personnel requirements - CPR and First Aid: The entire Asheville treatment team will receive CPR and First Aid training to ensure there is always at least one person in the building who has a current CPR card. The nurse who is a

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V 233	Continued From page 23 CPR trainer has attempted to contact the director of the local AHA office to obtain a copy of her current CPR card. If it is determined that the nurses do not have current CPR cards, they will be instructed to complete this by February 22, 2019, or earlier. A counselor at the treatment center is attending a CPR course tomorrow and will provide her proof of training when she returns to work on Friday. To prevent a future similar occurrence, the Program Director will keep track of all CPR expiration dates and notify team members of the need to renew their cards prior to expiration. This information is also included in the quarterly HR file reviews. -Training on alternatives to restrictive interventions: The team member missing the NCI training will have this completed on or before February 22, 2019. Additionally, the Regional Director will identify a member of the regional team to send to NCI trainer training within the next 30 days or as training schedule allows. The NCI training will be completed annually for all team members, and the Program Director will keep track of due dates via the HR file audit process. The Program Director will also be responsible for ensuring all new hires have completed the NCI training prior to the delivery of any services. -Location and exterior requirements: It is recognized that the Asheville Treatment Center building and exterior need cleaning and repairs. Plans are currently in place to begin repairs, starting with the roof on February 19th. Once the roof repairs are complete, the building will be painted, and new flooring installed. Plans are also in place to improve the overall appearance of the outside of the building and grounds. The Program Director will educate all team members about the need to assist with cleaning efforts and ensuring trash is not overflowing, cigarette butts	V 233		

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V 233	Continued From page 24 are picked up, and there is an overall neat appearance to the environment." Staff were hired without criminal checks and health care registry checks or those checks were conducted late. Staff were not trained in nature of addiction or group and family therapy. There was no current training in CPR for either nurse which meant at times there was no one in the clinic trained in that area. Staff had provided direct service to clients for months prior to being trained about alternatives to restrictive interventions. All four counselors carried caseloads that exceeded 50 clients. At least one of the four counselors indicated that her caseload had been over the requirement of 50 since she was hired in July 2018. Counseling sessions were missed for some clients and coordination of care with medical providers was not completed for clients who had co-occurring medical and/or psychiatric conditions. These clients were prescribed multiple medications that included psychotropic medications, medications for diabetes and high cholesterol, and blood thinners. Medical Assistants were collecting urine samples for drug tests without having been trained or tested for competence. Thirty eight urine samples were collected, not bagged according to protocol, and improperly stored in a sink. The carpet throughout the facility was dirty and stained. Deficient practice in some of these areas has been cited since 2016. There has been no leadership or oversight to ensure systems were in place to meet the requirements of the program or to ensure the treatment needs of their clients were met. These systemic failures are determined to be detrimental to health, safety and welfare and constitute a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be	V 233		

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V 233	Continued From page 25 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 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 maintain a ratio of one certified substance abuse counselor for every 50 clients	V 235		

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V 235	Continued From page 26 and failed to ensure 6 of 7 audited staff (Medical Assistant #1, Medial Assistant #2, Counselor #1, Counselor #2, Registered Nurse #1, Registered Nurse #2) were trained in nature of addiction, the withdrawal syndrome, group and family therapy, and infectious diseases including HIV, sexually transmitted diseases and TB. The findings are: Review on 2/11/19 of the current list of clients assigned to each counselor revealed: -Caseload for Counselor #1 was 55. -Caseload for Counselor #2 was 56. -Caseload for Counselor #3 was 59. -Caseload for Counselor #4 was 63. -The Program Director carried a caseload of 25. Review on 2/13/19 of the personnel record for Medical Assistant #1 revealed: -Date of hire was 7/30/18. -Certified Clinical Medical Assistant dated 5/16/18. -No training documented in Nature of Addiction, or Group and family therapy. Review on 2/13/19 of the personnel record for Medical Assistant #2 revealed: -Date of hire was 2/7/19. -No training documented in Nature of Addiction, Withdrawal Syndrome, Group and family therapy or infectious diseases. Review on 2/11/19 of the personnel record for Counselor #1 revealed: -Date of hire was 7/2/18. -LCAS-A (Licensed Clinical Addiction Specialist) dated 5/23/18 with expiration on 12/20/22. -No training documented in Withdrawal Syndrome, or Group therapy. Review on 2/11/19 of the personnel record for	V 235		

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V 235	Continued From page 27 Counselor #2 revealed: -Date of hire was 6/11/18. -CSAC-R (Certified Substance Abuse Counselor Registered) on 4/28/16. -No training documented in Nature of Addiction, or Group and Family therapy. Review on 2/11/19 of the personnel record for RN (Registered Nurse) #1 revealed: -Date of hire was 5/30/17. -Current Permanent RN license. -No training documented in Nature of Addiction, or Group and Family therapy. Review on 2/11/19 of the personnel record for RN (Registered Nurse) #2 revealed: -Date of hire was 7/23/18. -Current Permanent RN license. -No training documented in Nature of Addiction, or Group and Family therapy. Interview on 2/11/19 with Counselor #1 revealed: -Her caseload was 55. She had been over 50 since she was hired. She indicated her caseload was manageable. -She had no training. Recently they the agency had started to catch up on the training. -She stated that she had been trained in group and family therapy and withdrawal syndrome by a previous employee but not at this clinic. -She had resigned and would be leaving on 2/14/19. Interview on 2/11/19 with Counselor #2 revealed: -His caseload was 55. -His training included group therapy but no training in addiction, HIV, or withdrawal symptoms. Interview on 2/12/19 with the Program Director	V 235		

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V 235	Continued From page 28 and Director of Regulatory Affairs revealed: -The Program Director was responsible for coordination of training. -Prior program Director was not on site regularly and had failed to ensure that regulatory requirements were met. His employment was terminated on 11/27/18. There was no administrative leadership locally to oversee the former Program Director. -The former Director had no checks and balances in place. He failed to ensure that training requirements were met. -BHG provided a basic pharmacology training course that covered withdrawal syndrome. They would add "Addiction 101" for 2019. -Another check and balance would be added to ensure the Director was aware of trainings due at the beginning of every month. -They were unaware of the oversight of the former Program Director. -The Program Director carried a caseload of 25 clients. -One counselor had resigned. Her caseload was 55. -There were 2 new Licensed Counselors who would be starting soon. They did not, however like to give large caseloads to counselors as soon as they started. This deficiency constitutes a re-cited deficiency. This deficiency was cited on 2/21/18, 2/8/17, 9/15/16, and 2/26/16. 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 238	27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD	V 238		

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V 238	Continued From page 29 TREATMENT. OPERATIONS. (e) The State Authority shall base program approval on the following criteria: (1) compliance with all state and federal law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the 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	V 238		

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at the clinic each week;
(C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week;
(D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five take-home doses and shall ingest all other doses under supervision at the clinic each week;
(E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be 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;

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V 238	Continued From page 31 (B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and (C) The reinstatement of take-home eligibility shall be determined by each Outpatient Opioid Treatment Program. (3) Exceptions to Take-Home Eligibility: (A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a 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	V 238		

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treatment) for each state holiday.
(B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above.
(g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter.
(h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each 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

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V 238	Continued From page 33 Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for bottle checks, bottle returns or solid dosage form call-in's; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction; (5) client attendance minimums; and (6) procedures to ensure that clients properly ingest medication. This Rule is not met as evidenced by: Based on record review and interview the facility	V 238		

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V 238	Continued From page 34 failed to ensure that the required counseling sessions were provided to 5 of 10 audited clients (#1, #3, #4, #7, and #8). The findings are: Record review on 2/11/19 for Client #1 revealed: -Admitted on 3/22/18 with diagnosis of severe Opioid Use Disorder. -Client #1 only had one counseling session for December 2018 when he should have had two. Client #1 missed that session, however, another session was not attempted to meet the requirement for 2 in December. Record review on 2/11/19 for Client #3 revealed: -Admitted on 8/28/17 with diagnosis of severe Opioid Dependence. -No counseling session documented for Client #3 for the month of December 2018. Record review on 2/12/19 for Client #4 revealed: -Admitted on 12/14/17 with diagnoses of Opioid Dependence and pregnancy. -No counseling session conducted with Client #4 for the month of December 2018 and January 2019. Record review on 2/12/19 for Client #7 revealed: -Admitted on 6/25/18 with diagnoses of Substance Use Disorder and Depression. -Only one counseling session for the month of December 2018. Record review on 2/12/19 for Client #8 revealed: -Admitted on 2/21/17 with diagnoses of Opioid Dependence and Schizophrenia. -No counseling session conducted with Client #8 for the month of December 2018. Interview on 2/12/19 with the Program Director and Director of Regulatory Affairs revealed:	V 238		

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V 238	Continued From page 35 -Former program Director was not on site regularly and had failed to ensure that regulatory requirements were met. His employment was terminated on 11/27/18. There was no administrative leadership locally to oversee the former Program Director. -The former Program Director had no checks and balances in place. -Counseling sessions were conducted twice per month for the first year and then once per month after that. A "high-risk" client may be seen more frequently. -A "stop-dose" at the window was put in place as needed to alert clients to required counseling sessions. -Client charts were audited monthly to ensure that counseling sessions were provided. -Counselors should keep track of the counseling sessions for each client. -At times group sessions replaced an individual session. -Two new counselors had been recently hired. There had been a lot of turn over since May and June of 2018. -There was currently no Clinical Director. -The counseling sessions identified had not been provided to the clients. This deficiency constitutes a re-cited deficiency. This deficiency was cited on 2/21/18, 2/8/17, 9/15/16, and 2/26/16. 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 238		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON	V 536		

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V 536	Continued From page 36 ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (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	V 536		

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V 536	Continued From page 37 disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence 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	V 536		

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V 536	Continued From page 38 objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (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	V 536		

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V 536	Continued From page 39 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 interviews the facility failed to ensure staff had been trained in alternatives to restrictive interventions prior to providing services effecting 5 of 7 audited staff (Counselor #1, Counselor #2, Registered Nurse #2, Medical Assistant #1, and Medical Assistant #2). The findings are: Review on 2/12/19 of an Invoice dated 1/18/19 revealed that Counselor #1, Counselor #2, Registered Nurse #1, and Registered Nurse #2 were trained in NCI + Prevention but the invoice does not indicate the date that training occurred. Review on 2/11/19 of the personnel record for Counselor #1 revealed: -Hired on 7/2/18. -LCAS-A (Licensed Clinical Addiction Specialist) as of 5/23/18. -No documentation of training in alternatives to restrictive interventions. Review on 2/11/19 of the personnel record for Counselor #2 revealed:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHG ASHEVILLE TREATMENT CENTER	18 WEDGEFIELD DRIVE ASHEVILLE, NC 28806

(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 40 -Hired on 6/11/18. -CSAC-R (Certified Substance Abuse Counselor Registered) as of 4/28/16. -No documentation of training in alternatives to restrictive interventions. Review on 2/11/19 of the personnel record for Registered Nurse (RN) #2 revealed: -Hired on 7/23/18. -Active Permanent RN license maintained in the record. -No documentation of training in alternatives to restrictive interventions. Review on 2/13/19 of the personnel record for Medical Assistant #1 revealed: -Date of hire was 7/30/18. -Certified Clinical Medical Assistant dated 5/16/18. -No training documented in alternatives to restrictive interventions. Review on 2/13/19 of the personnel record for Medical Assistant #2 revealed: -Date of hire was 2/7/19. -No training documented in alternatives to restrictive interventions. Interview on 2/12/19 with the Program Director and Director of Regulatory Affairs revealed: -Former program Director was not on site regularly and had failed to ensure that regulatory requirements were met. -The former Program Director had no checks and balances in place. He failed to ensure that training requirements were met. -The training for alternatives to restrictive interventions was not conducted until January. -There had been no system in place to ensure that training occurred prior to service delivery.	V 536		

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V 536	Continued From page 41 This deficiency constitutes a re-cited deficiency. This deficiency was cited on 2/8/17 and 2/21/18. 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 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to maintain a safe, clean, attractive and orderly facility. The findings are: Observation on 2/11/19 at 8:47AM of the waiting room, bathrooms, hallways, and dosing area revealed: -The carpet in the waiting room area was heavily stained. There were dark stained areas throughout. -The carpet in the area where the two dosing windows were located had 3 dark stained areas and one burned area approximately 2 inches long and 1 inch wide. -The carpet in the hallway on the main level had 6 dark stained areas. -The carpet up the stairwell was heavily worn and stained. -The hallway through the upper level had two	V 736		

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V 736	Continued From page 42 large stained areas. -The exterior of the building had 2 trash cans and a cigarette dispenser. There were approximately 21 cigarette butts on the ground. -The vent covers in the both the men's restroom and women's restroom upstairs were missing the vent covers. -Water stains were observed around recessed lighting in the lobby ceiling. Interview on 2/12/19 with the Regional Director revealed: -There was a huge leak in the roof and a new roof was getting ready to be installed. -They had already consulted with contractors and electricians about repairs to the building. -They planned to do new landscaping outside. -They had obtained quotes on new flooring. Interview on 2/13/19 with the Program Director revealed: -At the end of January 2019 a new cleaning service was hired. This cleaning service cleaned the building twice per week. They cleaned the interior of the building only. -One of the counselors on staff routinely monitored the parking lot for cleanliness. -Prior to January 2019 one individual cleaned the building. That cleaning service contract was terminated when the last program director left. This deficiency constitutes a re-cited deficiency. 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 736		