Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-258	A. BUILDING: _____ B. WING _____	R 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS OF HOPE, LLP	33 DARLINGTON AVENUE WILMINGTON, NC 28403

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V 000	INITIAL COMMENTS An annual and follow up survey was completed February 8, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. The census at the time of the survey was 104.	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; (7) quality assurance and quality improvement	V 105	DHSR - Mental Health MAR 01 2019 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Program Director		2/28/19

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V 105	Continued From page 1 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 record reviews and interviews, the facility failed to develop and implement written	V 105	V105 27G. 0201 (A) 1. Policy to address Coordination of Care revised to include process of coordination of care at intake. 2. Intake assessment revised to include information on all providers including medical, dentistry, psychiatry, substance use and mental health. 3. Upon admission to the facility, patients will be required to sign releases of information for all reported providers. 4. Counselor will fax all releases to providers at time of admission.	03/04/19

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V 105	Continued From page 2 policies for the adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. The findings are: Finding #1: Review on 2/7/19 of client #168's record revealed: -49 year old female admitted 8/1/18. -Diagnosis of Opioid Use Disorder, severe -Physical examination documented 8/1/18. Physician documented client #168 previously took medications for high blood pressure, but had not taken any medication since January. The client reported she had an appointment with another provider the following Tuesday. -Client #168's blood pressure was 140/101. -The physician documented the client needed an EKG (electrocardiogram) and was asked to bring a copy to the clinic. -No documentation the client had an EKG done; no copy of an EKG on client #168's record. -No documentation there was follow up with the client to obtain an EKG and send the results to the clinic. -No documentation the client's blood pressure had been rechecked after her intake. -No documentation of medications for depression. Interview on 2/6/19 client #168 stated she took something for depression prescribed by the provider identified at intake. Interview on 2/8/19 Counselor #2 stated: -She referred client #168 to the same provider the client stated she had the appointment during her intake. This referral was specifically for Hepatitis C. -She had not followed up about the client's blood	V 105		

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V 105	Continued From page 3 pressure or EKG. Finding #2: Review on 2/7/19 of client #102's record revealed: -32 year old female admitted 3/16/18. -Diagnosis of Methadone maintenance -Physical examination documented 3/16/18. -Physician documented client #102 was receiving an antibiotic (Bactrim) by her primary care physician. -No documentation there was coordination of care with the client's primary care physician. Interview on 2/6/19 client #102 stated her primary care physician was the same as the one identified on intake. Interview on 2/8/19 Counselor #1 stated: -Nothing was sent to the counselor to coordinate care for client #168 on intake. -Typically the physician would send a note to the counselor if he identified a need for follow up. The counselor would initiate a coordination of care. The counselors do not read the physicians history and physical and did not see his hand written note about the client seeing a physician for her blood pressure and needed an EKG. -There should have been a coordination of care done with client #102's primary care when she was admitted. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 105		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse	V 235		

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V 235	Continued From page 4 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 reviews and interviews, the facility failed to provide required continuing education for 1 of 2 direct care staff audited (Licensed Practical Nurse (LPN) #7). The findings are: Review on 2/8/19 of LPN #7's record revealed: -Hired on 5/30/17 to be one of the licensed nurses. -Documented trainings related to the nature of addiction and the withdrawal syndrome were all	V 235		

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V 235	Continued From page 5 completed prior to hire in 2015. -No documentation of continuing education on group and family therapy. Interview on 2/7/19 LPN #7 stated: -She had been working for the clinic from the time it opened. -She had worked at another Methadone clinic in the community prior to her employment. -She had done online trainings related to addition and withdrawal. -She had printed the documentation of trainings and given to the Registered Nurse. Interview on 2/8/19 the Program Director stated she had checked and there were no other required trainings for the nature of addiction, the withdrawal syndrome, or group and family therapy documented for LPN #7 after she had been hired.	V 235	V 235 27G .3603 (A-C) Lisa Layman, MA, LPC, LCAS, NCC will provide continuing education for each direct care staff member on the understanding of group and family therapy. It is the responsibility of the CEO and Program Director to ensure that all staff receive continuing education as required.	03/25/19 Ongoing
V 238	27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD 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	V 238	V238 27 G. 3604 (E-K) Written material outlining the risks and benefits of withdrawl from Methadone and Buprenorphine has been added to the annual packet for review with patients. Counselors have met with all current patients enrolled in treatment for over one year and reviewed/discussed the risks and benefits. This material is also available at patients' request. It is the responisibility of the Counselors and Program Director to ensure that all patients receive information at intake and annually thereafter.	02/27/19

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V 238	Continued From page 6 specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month. (1) Levels of Eligibility are subject to the following conditions: (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic; (B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week; (C) Level 3. After 180 days of continuous 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	V 238		

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V 238	Continued From page 7 granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and (G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month. (2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility: (A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility by one level of eligibility; (B) A client who tests positive on three drug screens within the same 90-day period shall have 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	V 238		

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V 238	Continued From page 8 verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous treatment. (B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall make monthly clinic visits. (4) Take-Home Dosages For Holidays: Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following: (A) An additional one-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday. (B) No more than a three-day supply of 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	V 238		

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V 238	Continued From page 9 active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method. (i) Client Discharge Restrictions. No client shall be discharged from the facility while physically dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug. (j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are 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	V 238		

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V 238	Continued From page 10 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 reviews and interviews, the facility failed to discuss the risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment with each client annually for 4 of 4 clients audited who had been admitted to the program for more than 1 year (#014, #020, #053, #073). The findings are: Review on 2/8/19 of client #014's record revealed: -47 year old female admitted 8/10/17. -Annual physical was documented on 12/20/18. -Client had received Methadone 160 mg since 12/20/18. -Drug screens on 1/16/19, 12/20/18, 12/07/18, and 11/07/18 were positive for benzodiazepine. -Drug screen for 12/20/18 was positive for	V 238		

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V 238	Continued From page 11 opiates. -Client was prescribed Xanax 1mg twice daily. -No documentation the risks and benefits of withdrawal from methadone had been discussed with the client. Review on 2/8/19 of client #020's record revealed: -52 year old female admitted 8/14/17 -Annual physical was documented on 5/18/17 -Client had received Methadone 120 mg since 11/12/18. -Drug screen on 1/04/19 was positive for fentanyl and opiates. -No documentation the risks and benefits of withdrawal from methadone had been discussed with the client. Review on 2/8/19 of client #053's record revealed: -35 year old female admitted 10/27/17. -Annual physical was documented on 10/27/17. -Client had received Methadone 110 mg since 10/05/18. -Drug screens on 12/21/18 and 12/05/18 were positive for amphetamines. -Drug screens for 12/05/18 and 11/20/18 were positive for opiates. -No documentation the risks and benefits of withdrawal from methadone had been discussed with the client. Review on 2/8/19 of client #073's record revealed: -37 year old male admitted 12/14/17 -Annual physical was documented on 1/28/19. -Client had received Methadone 120 mg since admission. -Drug screens on 11/3/18, 12/10/18, 1/23/19, 1/28/19 were all positive for benzodiazepine.	V 238		

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V 238	Continued From page 12 -No prescription for a medication that would cause a positive benzodiazepine. -No documentation the risks and benefits of withdrawal from methadone had been discussed with the client. Interview on 2/8/19 Counselor #1 and the Program Director/Counselor stated: -They had no process in place to discuss the risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment with each client annually. -They would make sure this was put into place and documented. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 238		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal	V 536		

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V 536	Continued From page 13 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 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-258	A. BUILDING: _____ B. WING _____	R 02/08/2019

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V 536	Continued From page 14 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 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.	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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V 536	Continued From page 15 (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 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 reviews and interviews, the	V 536		

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V 536	Continued From page 16 facility failed to ensure all staff completed annual training in alternatives to restrictive interventions from an approved curriculum for 2 of 3 staff audited (Staff #4, Licensed Practical Nurse (LPN) #7). The findings are: Review on 2/8/19 of LPN #7's record revealed: -Position: Staff nurse. -Date of Hire: 5/30/17 -No current training on Alternatives to Restrictive Intervention. Review on 2/8/19 of Staff #4's record revealed: -Position/Title: Receptionist -Date of Hire: 5/18/18 -No current training on Alternatives to Restrictive Intervention. Interview on 2/8/19 Staff #4 stated: -There had been situations when a client escalated in front of her. -She always referred these clients to a counselor. -She did not feel unsafe in the facility. Interview on 2/7/19 the Program Director stated: -She was aware LPN #7's NCI (North Carolina Interventions) was expired. -She did not think the receptionist would need training because she would always be working with trained nurses and counselors. -They do not use restrictive interventions. -The facility had not chosen a curriculum now that NCI was no longer available. -She was aware they needed to choose a curriculum and have all staff trained on that curriculum.	V 536	The agency has chosen CPI for training in alternatives to restrictive intervention. 1.Staff has been enrolled in the first available CPI Train-the-Trainer model for certification as a CPI Instructor. 2.After completion of certification,all current staff will be trained and certified in CPI and annually thereafter. The Program Director is responsible for ensuring that all staff receive annual training in alternatives to restricitive intervention.	03/12/19-03/15/19 03/19/19

REFLECTIONS OF HOPE

February 28, 2019

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

Attached please find the Plan of Correction for the Annual and Follow-Up Survey completed on 02/08/19 at Reflections of Hope, LLP, MHL# 065-258.

If any additional information is needed, please do not hesitate to contact us immediately.

Respectfully,

Melissa A. Morris, CSAC-R, Program Director, CEO

DHSR - Mental Health
MAR 01 2019
Lic. & Cert. Section

33 Darlington Avenue
Wilmington, NC 28403
Ph: 910.782.8752
Fx: 910.782.8719