STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-065	A. BUILDING: _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA TREATMENT CENTER OF PINEHUI	20 PAGE DRIVE PINEHURST, NC 28374

(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 000	INITIAL COMMENTS An annual survey was completed on 5/30/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. The client census was 437 at the time of the survey.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to schedule a review of a plan at least annually affecting two of eighteen current audited clients (#1 and #2) and one of one deceased client (DC #3). The findings are: a. Review on 5/29/19 of client #1's record revealed: -Admission date of 11/30/09. -Diagnosis of Opioid Use Disorder. -Client #1 had a Master Treatment Plan dated 11/13/15. -There was no documentation that client #1 had a plan completed for 2019. b. Review on 5/29/19 of client #2's record revealed: -Admission date of 5/17/11. -Diagnosis of Opioid Use Disorder. -Client #2 had a Person Centered Plan dated 8/31/17. -There was no documentation that client #2 had a plan completed for 2019. c. Review on 5/29/19 of DC #3's record revealed: -Admission date of 10/25/12. -She died on 5/17/19. -Diagnosis of Opioid Use Disorder. -DC #3 had a Person Centered Plan dated 11/11/17. -There was no documentation that DC #3 had a plan completed for 2019. Interview on 5/29/19 and 5/30/19 with the Clinic Director revealed:	V 112		

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V 112	Continued From page 2 -The counselors were responsible for completing plans for clients. -She was not sure why the audited clients did not have a current plan. -She confirmed the facility failed to schedule a review of a plan at least annually for clients' #1, #2 and DC #3.	V 112		