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V 000	INITIAL COMMENTS An annual and follow up survey was completed on June 20, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4300 Therapeutic Community	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.	V 109		

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V 109	Continued From page 1 (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Qualified Professional (Medical Department Case Manager) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Record review on 6/18/19 for Client #1 revealed: -Admitted on 5/16/19 with diagnoses of Alcohol Dependence, Cocaine Dependence, Cannabis Dependence. Review on 6/18/19 of the Emergency Room Discharge Instructions revealed: -6/2/19 " ...Diagnois: Leg Edema, Orthopnea (shortness of breath) ...Please follow up with your primary care provider as soon as you are able. Follow up with Cardiology for ultimate management of this condition ..." -6/16/19 " ...Reason for visit: Trouble breathing and chest pain ...Diagnosis: Hypertension and Leg Edema ...You came to the emergency department for evaluation of shortness of breath and lower extremity edema ...Follow up with cardiology in 1 to 3 days ... Interview on 6/18/19 with Client #1 revealed: -He has had high blood pressure for 5 years. He indicated that years ago he had fluid buildup around his lungs and heart. He stated that was how he felt now.	V 109		

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V 109	Continued From page 2 -On 6/2/19 he went to the emergency room for swelling in his leg and foot. He stated the swelling was "very bad" and from the foot up to the knee. At the emergency room he stated his blood pressure was 220/130. He reported the hospital told him that he may have congestive heart failure and that he needed to see a Cardiologist. -He informed the Medical Case Manager that he needed to see a Cardiologist and she said ok. He never heard any more about it. He was aware that he had an appointment at a clinic on 6/20/19. He assumed the facility was waiting until he saw the regular doctor to schedule a visit with a Cardiologist. -He indicated that on 6/15/19 he experienced some tightness in his chest, a bad headache and swelling in his leg. He stated that he stayed in bed all day because he did not feel good. He told the House Manager that he did not feel good. The House Manager asked him if he wanted to take a sick day from work and he said yes. -On 6/16/19 he went to church but indicated that every time he stood up he got dizzy. After church he laid down and when he woke he felt like he was suffocating. He told the House Manager who arranged for his transportation to the emergency room. He stated that he was told at the emergency room (ER) that his condition was not congestive heart failure but possibly a "respiratory viral infection" and that all his cardiac testing performed was normal. The ER advised him to follow up with his doctor. Review on 6/17/19 of the personnel record for the Medical Department Case Manager revealed: -Date of Hire was 2/22/18. -Met qualifications for Qualified Professional. She was not a nurse and did not have experience in the medical field.	V 109		

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V 109	Continued From page 3 -Job Description indicated " ...Responsible for insuring that patients receive all appropriate services. Coordinate services provided by ancillary agencies ...Supervision of Medication Department and the compliance to medication policy and procedures ..." Interview on 6/18/19 with the Medical Department Case Manager revealed: -On 6/2/19 Client #1 went to the emergency room due to swelling in his legs. She stated he had just started working. The swelling resolved, and he did not complain of further symptoms, therefore she did not schedule follow up with a cardiologist. -She indicated that either she, a House Manager or the Administrative Director reviewed the discharge paperwork from hospital visits. She stated she would only schedule follow up appointments if symptoms persisted. -Client #1 had missed his medication on 6/15/19 and 6/16/19. She completed the Medical Clean Up Report on 6/17/19. She contacted the pharmacist on 6/18/19. The pharmacist advised her that Client #1 needed to be monitored for chest pain. -On 6/16/19 Client #1 went to the emergency room because he had trouble breathing and chest pain. -The hospital wanted Client #1 to have a follow up appointment with his primary care physician following the 6/16/19 visit. She scheduled Client #1 an appointment at a clinic for follow up on 6/20/19. She did not schedule follow up with a Cardiologist after the 6/16/19 Emergency room visit because she felt that the Primary Care Physician should make that referral. -She served as the Liaison with local medical providers to coordinate all medical appointments. This deficiency is cross referenced into 10A	V 109		

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V 109	Continued From page 4 NCAC 27G .4301 Scope (254) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement goals and	V 112		

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strategies to address the treatment needs effecting 3 of 9 audited clients (#2, #5, #6). The findings are:

Review on 6/18/19 of the Admission Information for the Program revealed:
-" ...The preppie phase will last 30 days or until initial treatment plan goals have been met ...During the preppie phase, between the hours of 6:30AM-9:30PM, clients will be scheduled a variety of activities including educational classes, group therapy, 12-step meetings, work assignments, chores, etc ...all clients will receive a work assignment after completion of the preppie phase in order to help support the house ..."

Review on 6/18/19 of the "Preppie Handbook" revealed:
-"...Working is an important part of recovery. A healthy work ethic will go a long way toward instilling self-discipline and responsibility...Our contract employers provide a variety of vocational training opportunities and the presence of their organization on a personal resume can be very beneficial to graduates of our program..."

Record review on 6/12/19 for Client #2 revealed:
-Admitted on 5/4/19 into the Long-Term Program (12 months) with diagnoses of Alcohol Use Disorder, Opioid Use Disorder, and Cocaine Use Disorder.
-He attended 9 groups that were part of the "Thinking for Change "series in May 2019.
-Treatment plan signed on 5/9/19.

Review on 6/18/19 of the work hour totals for Client #2 revealed:
-Began work on 5/6/19, 2 days following admission.

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V 112	Continued From page 6 -Weekly totals for work hours were as follows: week of 5/6/19 was 46.48, week of 5/13/19 was 59.2, week of 5/27/19 was 48, week of 6/2/19 was 47.45, and week of 6/10/19 was 56.88. Record review on 6/12/19 for Client #5 revealed: -Admitted on 4/8/19 into the Long-Term Program (12 months) with diagnoses of Opioid Use Disorder, Amphetamine Use Disorder, and Cannabis Use Disorder. -He attended 9 groups that were part of the "Thinking for Change "series, Infectious Disease and relapse prevention during the month of April. -He attended 1 "Thinking for Change" group in May and one 12-Step Group in May. -Treatment plan signed on 4/9/19. Review on 6/18/19 of the work hour totals for Client #5 revealed: -Began work on 4/9/19, the day following admission. -Weekly totals for work hours were as follows: week of 4/8/19 was 23.6, week of 4/15/19 was 47.95, week of 4/22/19 was 23.97, week of 4/29/19 was 65.07, week of 5/6/19 was 46.92, week of 5/13/19 was 71.5, week of 5/20/19 was 31.2, week of 5/20/19 was 31.2, week of 5/27/19 was 36, and week of 6/3/19 was 4. Record review on 6/12/19 for Client #6 revealed: -Admitted on 3/11/19 into the Long-Term Program (12 months) with diagnoses of Opioid Use Disorder and Cocaine Use Disorder. -He attended 12 groups that were part of the "Thinking for Change "series and one group on personal finance during the month of March 2019. -He attended 5 "Thinking for Change" groups in May and one group on the Neuro Science of Addiction in April.	V 112		

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-He attended 1 group in May 2019.
-Treatment plan signed on 3/13/19. As Client #6's engagement in required treatment meeting began to decline there were no strategies added to the treatment plan to address this issue.

Review on 6/18/19 of the work hour totals for Client #6 revealed:
-Began work on 3/19/19.
-Weekly totals for work hours were as follows: week of 3/18/19 was 34.22, week of 3/25/19 was 39.38, week of 4/1/19 was 43.53, week of 4/8/19 was 38.7, week of 4/15/19 was 26.81, week of 4/22/19 was 42.83, week of 4/29/19 was 39.08, week of 5/6/19 was 50.32, week of 5/13/19 was 50.22, week of 5/20/19 was 59.52, week of 5/27/19 was 55.8, week of 6/3/19 was 60, and week of 6/10/19 was 67.2.

Review on 6/17/19 of the Long-Term Residential Program Treatment Plan revealed:
-The treatment plan was a standardized document and the same for all clients.
-Treatment plan was divided into 5 problem areas: Substance Use, Psychological, Family/Social, Education/Employment, and Legal.
-Goals for Substance Use were: remain clean and sober; develop skills to prevent relapse; reduce denial around chemical use, and increased knowledge of substance use and recovery. Interventions for these goals included: attend all Phase 1 groups; attend Thinking for a Change groups in Phase 1; attend 12-step meetings at least 3 times per week; complete group series in 12-step, Relationships, Anger Management and Relapse Prevention; and individual counseling as needed.
-Goals for Psychological were: Improve psychiatric and/or emotional symptoms; understand and reduce concentration issues and

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anxiety, depression or withdrawal symptoms. Interventions for these goals included: take medications as directed, attend outside counseling/meetings as needed; and attend medical appointments if applicable.
-Goals for Family/Social were: Maintain/Improve family and social relationships; and build a healthy support network. Interventions for these goals included: be involved in recovery community such as AA (Alcoholics Anonymous), NA (Narcotics Anonymous) or Celebrate Recovery; share in groups three times per week; obtain and maintain consistent contact with a sponsor and appropriate family members.
-Goals for Education/Employment were: Learn job skills; create a positive work history; earn good work references; and obtain a job interview. Interventions for these goals included: participate in all work assignments; meet with employment specialist; and complete all related assignments.
-Goals for Legal were: Obtain favorable legal outcome. Interventions for these goals included: attend probation appointments as scheduled, complete any additional court requirements, and complete weekly activity logs or update sheets.
-The treatment plan did not include target dates. There was no way to determine when a client had completed Phase 1 of the program.

Review on 6/19/19 of the Phase One ("Preppie Phase") Daily Schedule revealed:
-From Monday through Friday there were 5 daily meetings between the hours of 7:45AM and 9:00PM.
-Weekend schedule included one meeting each day.

Review on 6/17/19 of the Meeting and Group Schedule for Phase 2 revealed 7 meetings were offered daily between the hours of 7:45AM and

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V 112	Continued From page 9 8:00PM. Interview on 6/6/19 with Client #2 revealed: -He had been in the program for approximately 30 days. He worked a 3rd shift job. His work hours were 6PM-6AM. He usually worked 5 days. -On his days off he would attend groups and "tried to attend outside meetings." -Some other residents worked 7 days of 12-hour shifts and had talked to the Facility Assignment Coordinator about it. -He indicated that he could not attend meetings as much as he would like to. -He stated it was too hard to get the benefit of meetings when he worked a 12 hour shift every night. Interview on 6/6/19 with Client #5 revealed: -He had worked 12-hour shifts since his admission. His last day was 6/5/19. -He also worked in the facility laundry on his days off from the contract job. He had started that job three weeks prior. -He had worked 2 weeks back to back with 1 day off in between. Usually he worked 5 days, 12-hour shifts. With transportation included he would leave for work at 5AM and return to campus at 7PM. -He felt he had no time for his recovery. He stated there was no time to attend meetings. -He stated that approximately three weeks ago he went to the Facility Assignment Coordinator who contacted the employer and told them he could no longer work that many hours. -Two weeks ago, he was pulled off the contract and then sent back the following day to work a two week notice. -On 6/5/19 he felt "shaky and weak" while at work. He went to take his break and "passed out"	V 112		

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while at work. He was taken to the emergency room and medical staff indicated it could have been exhaustion or dehydration. That was his last day on that work contract. Prior to this, however, he was working both the "notice" and in the campus laundry facility.
-He indicated that he had not been to a meeting lately. He estimated 15 meetings since admission. He did not have a sponsor yet.

Interviews on 6/6/19 and 6/12/19 with Client #6 revealed:
-When he started working he was assigned an 8-hour shift. He stated that he enjoyed the job and had weekends off so that he could attend meetings.
-He was switched to third shift and stated that he was "working all the time."
-"I have checked out."
-He was working usually 4-5 days per week. One week he had worked 72 hours.
-He had not been to a meeting since he went to third shift.
-"I couldn't tell you the last time I went to a meeting."
-He was given worksheets to complete on his own time because of his work schedule.

Interviews on 6/17/19 and 6/18/19 with the Facility Assignment Coordinator revealed:
-He assigned work placements for clients and monitored the work contracts.
-With each contractor they agreed upon hours worked and the hourly rate paid.
-The contractor offered 3 eight hour shifts and a 12 hour "swing shift." If working the 12 hour shift the total work hours for a week was 44 hours.
-When the contract began the clients worked 8-hour shifts, then the company wanted positions filled on the production floor. Those shifts were

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the 12-hour shifts.
-There have been inconsistencies with this contractor in that some clients were assigned jobs prior to the end of 30 days and clients began working longer hours.
-The first 30 days (Phase 1) in the program was the "preppie phase." The clients were required to attend 4-5 recovery groups per day and were assigned 3-4 "clean ups" per day.
-He indicated that "in theory" clients were not to be working during the preppie phase, but the reality was that some clients did work.
-Phase 2 was months 2-12 of the program and clients where given a work assignment. During Phase 2 clients were to attend 12 meetings per month to satisfy the curriculum that needed to be completed prior to graduation.
-He had received complaints about long work hours which he investigated and addressed with the employer.
-He stated it was "easy to get caught up in the work schedule."
-He was aware it got out of balance but that did not go on too long.
-Clients #2, #5 and #6 all went to work prior to completion of Phase 1.
-Client #6 started working an 8-hour second shift position but that position dissolved. He was then placed in a 12-hour overnight position. He reported a problem with the 12-hour shift but chose to continue in the position.
-He indicated that the 12-hour shifts were problematic and stated that the clients needed to work less.
-Client #5 had reported 2 weeks of long hours and the issue was addressed.
-He indicated that clients were working too much to attend meetings. He felt that work hours needed to be capped.
-Some clients will say they don't want to go to

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V 112	Continued From page 12 work at the last minute and as a result the House Manager had to scramble to find a replacement. They typically would approach clients who would say yes. -He had reached out to the contractor who agreed to work with the facility to resolve the problem. Interviews on 6/17/19 and 6/19/19 with the Program Director revealed: -An assessment was conducted with each new client upon admission to the program. The client would then sign the treatment plan. -Treatment plans were individualized to the program, not to the client. -Treatment plans were designed to be broad and cover the big picture. -A client's treatment plan was reviewed 10 months in to the program to determine at that time what had been accomplished. -The treatment plan was not typically updated except one time per year. -During the first 30 days the goal was for clients to attend groups, not be at work. -After the first 30 days when clients started work, they began mandatory evening groups. If they were unable to make the meeting he would provide them with homework assignments and remind them of meeting requirements that needed to be met. -The meetings provided were a 12-week 12 step program, 8-week Relationships series, 8-week Anger Management series, and 8 week Relapse Prevention series. Interviews on 6/12/19,6/17/19, 6/18/19 and 6/19/19 with the Administrative Director revealed: -When clients entered the program, they started in the "preppie phase." This phase lasted 30 days.	V 112		

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V 112	Continued From page 13 -He stated that "ideally" clients did not work during the preppie phase but rather engaged in groups and classes. -Clients worked jobs either on the property or in the community. -Employment contracts were established with companies in the community. -The Contracts Manager scheduled work and clients should not be working more than 45 hours per week. Clients should have 3 days off per week. Some clients may volunteer for additional hours. -There was no set number of meetings a week or month that clients had to complete but they were required to complete all educational classes prior to graduation from the program. -Some client work hours were above where they needed to be. The role of the Contracts manager was shifting to better manage the work schedules. -"We cannot let people work 70 hours a week." -Initial goals into the program were to attend groups, stabilize from active drug use and get oriented to the program. -Goal progress was monitored by a combination of the House Managers, clinical staff, the Contracts Manager and peer leaders. -A clinical staff member completed the initial treatment plan. The plan was reviewed annually. -There was no expectation to review the plan for progress or goal achievement more than once a year. This deficiency is cross referenced into 10A NCAC 27G .4301 Scope (254) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 118	27G .0209 (C) Medication Requirements	V 118		

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V 118	Continued From page 14 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure medications were administered as ordered, failed to ensure that all medications administered were ordered by	V 118		

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a person authorized by law to prescribe drugs, and failed to ensure MARs were current for 4 of 9 audited clients (#1, #2, #3, #4) and 1 of 1 paraprofessional staff (Admissions Assistant) failed to demonstrate competency in the administration of medications. The findings are:

a) Client #1:

Record review on 6/18/19 for Client #1 revealed:
-Admitted on 5/16/19 with diagnoses of Alcohol Dependence, Cocaine Dependence, Cannabis Dependence.

Review on 6/18/19 of the physician orders for Client #1 revealed:
-Physician's order dated 5/15/19 for Carvedilol 25mg, 1 tablet twice daily.
-Physician's order dated 5/15/19 for Spironolactone 25mg, one tablet daily.
-Physician's order dated 5/15/19 for Amlodipine Besylate 5mg, one tablet daily.
-Physician's order dated 5/15/19 for Isosorbide Monoitrate 30mg, one tablet daily.
-Physician's order dated 5/15/19 for Hydralazine 100mg, one tablet daily.
-Revised Physician's order dated 5/16/19 for Carvedilol 25mg, one half tablet twice daily.
-Physician's order dated 5/16/19 for Lasix 40mg, one tablet twice daily.
-Physician order to Self-Administer Medications dated 4/12/19.

Observation on 6/18/19 at 9:29AM of the medications for Client #1 revealed:
-Carvedilol (Blood Pressure and Heart Failure) 25mg, dispensed 5/14/19.
-Spironolactone (Blood Pressure and Diuretic) 25mg, dispensed 5/14/19.
-Hydralazine (Blood Pressure) 100mg, dispensed

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5/14/19.
-Isosorbide Monoitrate (Prevents chest pain and angina) 30mg, dispensed 5/14/19.
-Amlodipine Besylate (Blood Pressure and chest pain) 5mg, dispensed 5/14/19.
-No Lasix (Diuretic) available.

Review on 6/18/19 of the 05/2019-06/2019 MARs for Client #1 revealed:
-Client #1 signed his initials on the MARs every AM and PM when he self-administered his medications.
-The PM administration of Carvedilol was not documented on 5/31/19.
-Hydralazine was not documented as administered in May.
-Spironolactone was documented twice daily although ordered as once daily from 5/18/19-5/30/19.
- The PM administration of Carvedilol was not documented on 6/1/19 and 6/16/19.
-Isosorbide Monoitrate was not documented as administered on 6/15/19 and 6/16/19.
-No Lasix administered.

Review on 6/18/19 of the Emergency Room Discharge Instructions revealed:
-6/2/19 " ...Diagnosis: Leg Edema, Orthopnea (shortness of breath) ...Please follow up with your primary care provider as soon as you are able. Follow up with Cardiology for ultimate management of this condition ..."
-6/16/19 " ...Reason for visit: Trouble breathing and chest pain ...Diagnosis: Hypertension and Leg Edema ...You came to the emergency department for evaluation of shortness of breath and lower extremity edema ...Follow up with cardiology in 1 to 3 days ...

Interview on 6/18/19 with Client #1 revealed:

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V 118	Continued From page 17 -He has had high blood pressure for 5 years. He indicated that years ago he had fluid buildup around his lungs and heart. He stated that was how he felt now. -On 6/2/19 he went to the emergency room for swelling in his leg and foot. He stated the swelling was "very bad" and from the foot up to the knee. At the emergency room he stated his blood pressure was 220/130. He reported the hospital told him that he may have congestive heart failure and that he needed to see a Cardiologist. -He informed the Medical Department Case Manager that he needed to see a Cardiologist and she said ok. He never heard any more about it. He was aware that he had an appointment at a clinic on 6/20/19. He assumed the facility was waiting until he saw the regular doctor. -He indicated that on 6/15/19 he experienced some tightness in his chest, a bad headache and swelling in his leg. He stated that he stayed in bed all day because he did not feel good. He told the House Manager that he did not feel good. The House Manager asked him if he wanted to take a sick day from work and he said yes. -On 6/16/19 he went to church but indicated that every time he stood up he got dizzy. After church he laid down and when he woke he felt like he was suffocating. He told the House Manager who arranged for his transportation to the emergency room. He stated that he was told at the emergency room (ER) that his condition was not congestive heart failure but possibly a "respiratory viral infection" and that all his cardiac testing performed was normal. The ER advised him to follow up with his doctor. -He stated on the date of this interview that he still didn't feel good. He still felt tightness in his chest and was experiencing congestion/wheezing. -Many doctors had asked him if he took Lasix	V 118		

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because they told him it was best for the fluid retention.
-He thought he was already taking Lasix.
-He self-administered his medication. At "med call" the staff person would hand him his medications and he would take them. He stated that the Medical Department Case Manager was the only staff that tried to make sure he took his medications.
-He missed his medications at times due to work or if he was sick in bed.
-Initially when he entered the program he was aware he should pick up his medications to take with him to work.
-He worked 8-hour shifts, usually 40 hours per week. His hours started to increase to 48 or 50 hours. He started noticing the swelling in his feet two and half weeks prior. The swelling has continued to get worse.

b) Client #2:

Record review on 6/12/19 for Client #2 revealed:
-Admitted on 5/4/19 with diagnoses of Alcohol Use Disorder, Opioid Use Disorder, and Cocaine Use Disorder.

Review on 6/6/19 of the physician orders for Client #2 revealed:
-Physician orders dated 5/8/19 for Oxcarbazepine 150mg, 1 twice daily; and Bupropion 150mg, 1 daily.
-No signed physician's order for 100mg Bupropion. The facility obtained a copy of an electronic order dated 4/23/19 from the pharmacy, however, that order was not signed by the physician.
-Physician order to Self-Administer Medications dated 4/29/19.

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V 118	Continued From page 19 Observation on 6/6/19 at 1:32PM of the medications for Client #2 revealed: -Oxcarbazepine (anti-convulsant) 150mg, dispensed 5/29/19. -Bupropion (depression) 100mg, dispensed 5/29/19. Review on 6/18/19 of the 05/2019-06/2019 MARs for Client #2 revealed: -Client #2 began taking medications on 5/6/19 prior to the physician orders. -Bupropion was charted twice daily 5/21/19-5/23/19. -Client #2 has received 100mg Bupropion daily although ordered at 150mg. Interview on 6/6/19 with Client #2 revealed: -He confirmed that he took both medications indicated daily. He self-administered his medications in the presence of a House Manager or the Medical Department Case Manager. c) Client #3: Record review on 6/12/19 for Client #3 revealed: -Admitted on 3/28/19 with diagnoses of Cocaine Use Disorder and Amphetamine Use Disorder. Review on 6/6/19 of the physician orders for Client #3 revealed: -No physician orders for any medications on 6/6/19. -No order to self-administer medications. A Physician's order to self-administer medications was obtained on 6/10/19. -Physician orders were obtained and dated 6/10/19 for Fiber 625mg, 2 daily; Tylenol 650mg, 1 three times daily as needed; Omeprazole 20mg, 1 daily; Cyclobenzaprine 10mg, 1 three times daily as needed; and Meloxicam 15mg, 1	V 118		

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V 118	Continued From page 20 daily. Observation on 6/6/19 at 1:49PM of the medications for Client #3 revealed: -Fiber 625mg, dispensed 2/13/19. -Tylenol 650mg, dispensed 2/22/19. -Omeprazole (acid reflux) 20mg, dispensed 5/21/19. -Cyclobenzaprine (muscle relaxant) 10mg, dispensed 5/21/19. -Meloxicam (anti-inflammatory) 15mg, dispensed 5/21/19. Review on 6/18/19 of the 03/2019-06/2019 MARs for Client #3 revealed: -Client #3 had taken Fiber, Omeprazole and Meloxicam daily since admission without physician orders. -Client #3 had taken Tylenol and Cyclobenzaprine as needed since admission without physician orders. -On 5/11/19 the Fiber, Omeprazole and Meloxicam were not documented as administered. Interview on 6/6/19 with Client #3 revealed: -He confirmed his daily medications and stated that he received them daily. He self-administered his medications in the presence of a House Manager or the Medical Department Case Manager. d) Client #4: Record review on 6/12/19 for Client #4 revealed: -Admitted on 4/4/19 with diagnoses of Bi Polar Disorder, Depression, Anxiety, Amphetamine Use Disorder, Alcohol Use Disorder, and Opioid Use Disorder.	V 118		

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Review on 6/6/19 of the physician orders for Client #4 revealed:
-No physician orders for any medications.
-No order to self-administer medications.
-On 6/17/19 prior to the close of the survey physician orders were obtained dated 6/17/19 for Client #4 to taper off both medications.

Observation on 6/6/19 at 2:02PM of the medications for Client #4 revealed:
-Buspirone 5mg, dispensed 3/25/19.
-Fluoxetine 10mg, dispensed 3/25/19.

Review on 6/6/19 of the 04/2019-06/2019 MARs for Client #4 revealed:
-Client #4 began talking his medications on 4/6/19.
-The Buspirone and Fluoxetine were not documented as administered on 4/14/19, 5/30/19, and 6/2/19.

Interview on 6/6/19 with Client #4 revealed:
-He confirmed his daily medications and stated that he received them daily. He self-administered his medications in the presence of a House Manager or the Medical Department Case Manager.

Review on 6/20/19 of the personnel record for the Admissions Assistant revealed:
-Date of Hire was 12/14/18.
-Met qualifications for a paraprofessional staff.
-Job Description indicated " ...Responsible for insuring that patients receive all appropriate services for admission to the program. Coordinate services provided by ancillary agencies ...Responsible for phone interviews and pre-assessments in coordination with other treatment team members ...Responsible for maintaining the patient's chart in compliance with

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V 118	Continued From page 22 State of North Carolina licensure regulations and other rules and standards ..." Interview on 6/18/19 with the Admissions Assistant revealed: -She received the initial physician orders (dated 5/15/19) for Client #1. The doctor sent another form which included the Lasix. -When Client #1 got to the facility he did not have Lasix. -She called the doctor but she indicated it was going to take too long to get the Lasix so she used the physician orders dated 5/15/19 which did not include that drug. -She indicated that Client #1 stated he didn't want to be on Lasix. -She did not obtain an order to discontinue the Lasix and there was no further consultation with the physician. Interviews on 6/6/19 and 6/18/19 with the Director of Admissions revealed: -Admissions was the first point of contact for clients coming into the program. They will obtain the application which included forms to be completed for physician order, over the counter physician orders and self-administration authorization. -Sometimes medications may have changed by the time clients arrived. -DPS (Department of Public Safety) clients usually came directly from prison and arrived without necessary paperwork. The admissions were usually very fast and last minute. -Client #1 was admitted following placement in a detox program. The physician orders dated 5/15/19 for Client #1 were sent prior to admission. -When he arrived with the discharge paperwork the physician orders dated 5/16/19 were included. She did not see those orders at the time of his	V 118		

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admission. The Admissions Assistant did not alert her to the discrepancy in medication orders.
-The protocol was to call the doctor if there was a discrepancy and to follow the directive of the physician. That call was not made.

Interviews on 6/6/19 and 6/18/19 with the Medical Department Case Manager revealed:
-Her responsibilities included a review to ensure physician orders align with medications, meeting with clients to discuss medications and the necessity of taking them timely, schedule transportation for medical appointments, work with mobile crisis as needed, and serving as the liaison with medical providers to coordinate appointments.
-Client #3 and Client #4 were both admitted directly from prison.
-She was advised that the facility could not obtain physician orders from the prison. She was told the prison physicians would not share that information.
-The protocol for DPS clients was to schedule a doctor's visit with a medical provider in the community.
-They used 2-3 local providers as primary care physicians for their clients.
-Client #3 was scheduled on 6/10/19 to see the medical provider and on that date, they would be able to obtain orders.
-Client #4 was scheduled on 7/24/19 to see the medical provider and on that date, they would be able to obtain orders.
-It took a while to get new clients established with a local medical provider. The medical provider that would see Client #3 and Client #4 had a two-month waiting period.
-She was unaware of the Bupropion milligram discrepancy for Client #2. She stated it was either an oversight on her part or the doctor had

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written the wrong dosage on the order sheet. Client #2 came with 100mg tablets.
-She had only seen the 5/15/19 physician orders for Client #1. The orders dated 5/16/19 that included the Lasix were not given to her. Client #1 never took Lasix.

Interviews on 6/12/19 and 6/18/19 with the Administrative Director revealed:
-He thought that the Medical Department Case Manager was reviewing MARs daily or at least every other day for errors.
-He was unaware that Lasix had been ordered for Client #1 and was never administered.
-The facility received notification that a DPS client was approved for admission at the most a week before but sometimes it was the same day.
-He indicated that they were not made aware of medications until the day of admission.
-When the client arrived sometimes they had their medication and sometimes they did not.
-They set up an appointment to get clients established with a local medical provider as soon as possible. At that time, they would obtain physician orders.

Review on 6/12/19 and 6/20/19 of the plan of protection completed and signed on 6/20/19 by the Administrative Director revealed:

"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?
FIRST contacted [local medical ministry] in Asheville, NC, on 6/12/2019 to discuss referring clients without Physician's Orders to [local medical ministry] as a bridge until the client's primary care physician can be established at the [local clinic] or other area provider. [Local medical ministry] agreed to serve in this capacity. [Local

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medical ministry] agreed to see clients and address medication refills providing Physician's Orders until individual clients have acquired primary care.
An appointment at [local medical ministry] was scheduled for the client #1 identified in the survey. The appointment was Monday June 17, 2019 at 8:30am, which was the first appointment available. Physician's orders were obtained for Client #1 and placed in the MAR.
FIRST's Case Management Department will identify other clients in need of Physician's Orders and schedule appointments accordingly. This identification and scheduling process will take place on an ongoing basis and will be monitored by the Administrative Director.
Client #2 identified in the Survey was scheduled for [local medical ministry] June 18, 2019 to obtain the medication missing from his most recent Physician's Order. The medication was obtained on June 18, 2019. Client #2 is scheduled for a Primary Care appointment at the [local medical clinic] in Asheville on Thursday June 20, 2019. [Local medical clinic] will provide primary care for Client #2 for the remainder of his time at FIRST.
FIRST's Director of Admissions addressed the decision making process of the Admission's Assistant in regard to the decision made about Client #2's Physician's Order. The Director of Admissions will review the applications of all program applicants and verify that their medication brought to the facility matches the Physician's Order obtained prior to arrival. The Director of Admissions will provide additional training to the Admission's Assistant on this process.
Describe your plans to make sure the above happens.
FIRST's Director of Admissions will ensure that

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V 118	Continued From page 26	V 118		

program applicants have Physician's Orders, Standing Orders for Medication, and Self-Administration Authorization Forms for new admissions to the program. The Director of Admissions will ensure that the most up-to-date order is conveyed and passed to the Case Management and Medical Department upon a client's admission. Clients will not be admitted to the long-term program component if they arrive on campus with medications that do not match the Physician's Orders obtained during the application process.
FIRST's Case Management Department will ensure appointments at [local medical ministry] are scheduled for DPS Transitional Housing and Step-Down Housing clients, or clients who are referred to the program without Physician's Orders. The Case Management Department will also schedule an initial primary care appointment for the client at the [local medical clinic] or other area provider. FIRST will utilize [local medical ministry] as a bridge until the primary care appointment is attended. We will utilize [local hospital] Emergency Department should a situation arise where a client is unable to obtain Physician's orders by this process. The Case Management Department will review the MAR daily for medication errors and contact a pharmacist and/or physician as needed when an error takes place. Errors will be documented on the Medical Clean Up Incident report. Additional training will be provided and directed by the Administrative Director on the procedure to obtain Physician's Orders, Standing Orders, Self-Administration Orders, and how to document medication errors."

Client #1 had a history of hypertension and edema. Prior to admission physician orders were sent followed by revised orders which showed the

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V 118	Continued From page 27 addition of Lasix. The Admission's Assistant failed to contact the physician to clarify the medication discrepancy and used the original orders that did not include Lasix. Client #1 never received the Lasix that was ordered by the physician. Subsequently, Client #1 had 2 ER visits on 6/2/19 and 6/16/19 for edema, shortness of breath, and chest pain. Client #2, Client #3 and Client #4 were admitted with medications but no physician orders in place. Orders were obtained for Client #2 two days following admission, however, he was taking a lower dosage of Bupropion than what had been ordered. This discrepancy was not identified nor addressed, and Client #2 has continued to take a lower dose of his psychotropic since admission. Client #4 and Client #5 have received medications without physician orders for two and a half months. These medications were for both medical and psychiatric conditions. The facility failed to put checks and balances in place to address and resolve medication discrepancies, to have physician orders for all medications prescribed and failed to ensure that each client was administered the prescribed dosage amount of their medication. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal:	V 119		

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V 119	Continued From page 28 (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to dispose of medications in a manner that guards against diversion or accidental ingestion. The findings are: Observations on 6/6/19 at 2:39PM of over the counter medication storage revealed: -Excedrin, expired in May 2018. -Four boxes of Phazyme expired in April 2019.	V 119		

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V 119	Continued From page 29 -Aspirin (325mg) expired December 2018. -Bactine expired December 2018. -Milk of Magnesia, expired April 2019. -Povidone Iodine expired July 2018. -Chito Rhino Mist, expired April 2019. -Tummy Zen expired March 2019. Interview on 6/18/19 with the Medical Case Manager revealed: -Some of the expired over the counter medications were obtained from a local food bank. She had inventoried and removed expired medications before, but she thought that possible someone was still bringing them in. She wasn't sure where all the expired medications came from. Interviews on 6/12/19,6/17/19, 6/18/19 and 6/19/19 with the Administrative Director revealed: -The Medical Case Manager was responsible to inventory over the counter medications to ensure none of them were expired. There was no established system or timeframe for how or when that was done. The Medical Case Manager had no idea how the expired medications made their way into the medication supply.	V 119		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. .	V 123		

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V 123	Continued From page 30 This Rule is not met as evidenced by: Based on record review and interview the facility failed to immediately notify a physician or pharmacist of medication errors for 1 of 9 audited clients (#1). The findings are: Record review on 6/18/19 for Client #1 revealed: -Admitted on 5/16/19 with diagnoses of Alcohol Dependence, Cocaine Dependence, Cannabis Dependence. Review on 6/18/19 of the "Medical Clean Up Report" documentation revealed: -"Medical Clean Up Report" dated 6/17/19 for Client #1 not taking a prescribed medication on the morning of 6/15/19 and 6/16/19. -The form did not indicate contact with a pharmacist or physician, recommendations obtained, nor action taken by staff. Interview on 6/18/19 with the Medical Case Manager revealed: -At the end of every month she reviewed MARs (medication administration records) for missed doses. -She was not identifying medication errors daily. -She wrote "behavior alerts" when clients missed their medication doses. The Behavior Alert form was used because they viewed missed medications as more of a behavior issue. There was also a "Medical Clean Up" form to use but she had not used this form until Client #1 missed medication doses on 6/15/19 and 6/16/19. -Client #1 had missed his medication on 6/15/19 and 6/16/19. She completed the form on 6/17/19. She contacted the pharmacist on 6/18/19. The	V 123		

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V 123	Continued From page 31 pharmacist advised her that Client #1 needed to be monitored for chest pain. -She was not aware that the pharmacist or physician had to be contacted immediately. -There was no system in place for other staff who monitor the administration of medications to report medication errors. Interviews on 6/12/19,6/17/19, 6/18/19 and 6/19/19 with the Administrative Director revealed: -He assumed the Medical Case Manager was reviewing MARs (medication administration records) daily or at least every other day. If there was a medication error, they usually called the pharmacist first and may follow up with the physician if necessary. This deficiency is cross referenced into 10A NCAC 27G .4301 Scope (254) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 254	27G .4301 Therapeutic Community - Scope 10A NCAC 27G .4301 SCOPE (a) A Therapeutic Community is a highly structured, supervised, 24-hour residential facility designed to treat the behavioral and emotional issues of individuals to promote self-sufficiency and a crime and drug-free lifestyle. (b) The Therapeutic Community shall emphasize self-help, abstinence from drugs and alcohol, personal growth, peer support, and may serve as an alternative to incarceration. (c) Services shall be designed to create the environment of an extended family in which individuals develop self-esteem, construct a productive lifestyle through peer support and actual experience, leading to a successful re-entry into the larger community.	V 254		

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V 254	Continued From page 32 (d) The facility shall provide or ensure access to a variety of intensive therapy and program milieu approaches designed to confront and modify the client's anti-social and dysfunctional behavior. (e) The goal shall be to assist the client in learning socially acceptable skills for coping with responsibilities and relationships, and to maintain a lifestyle which is substance abuse free. (f) Consideration shall be given to meeting client needs in social, medical, psychological, vocational and educational areas. (g) If children are residing in a Therapeutic Community, the facility shall also meet the rules for Therapeutic Homes for Individuals with Substance Abuse Disorders and Their Children set forth in Section .4100 of this Subchapter except for 10 NCAC 27G .4102(c), .4102(e), .4103(2), and .4104(b). This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to meet client needs in social, medical, psychological, vocational and educational areas, effecting 4 of 9 audited clients (#1, #2, #5, #6). The findings are: Cross reference: 10A NCAC 27G .0203 Competencies of Associate Professionals and Qualified Professional (V109) Based on record reviews and interviews, 1 of 1 Qualified Professional (Medical Department Case Manager) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or	V 254		

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V 254	Continued From page 33 Service Plan (V112) Based on record review and interview the facility failed to develop and implement goals and strategies to address the treatment needs effecting 3 of 9 audited clients (#2, #5, #6). Cross reference: 10A NCAC 27G .0209 Medication Requirements (V123) Based on record review and interview the facility failed to immediately notify a physician or pharmacist of medication errors for 1 of 9 audited clients (#1). Cross reference: 10A NCAC 27G .4303 Staff (V256) Based on record review and interview the facility failed to ensure 4 of 6 audited staff (House Manager, Medical Department Case Manager, Veterans Case Manager, and Admission's Assistant) were trained in the required program specific trainings for the population served. Review on 6/12/19 and 6/20/19 of the plan of protection completed and signed on 6/20/19 by the Administrative Director revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "FIRST's Administrative Director met with the Medical Department Case Manager and Director of Admissions on June 20, 2019 to discuss the errors of the Medical Case Manager and Admission's Assitant as a result of the Physician's Order around Client #2, the Admission's Assistant's, the failure to schedule Client #2 with a specialist as recommended, and the timely documentation of medication errors. Effective immediately the Director of Admissions will review the applications of all program applicants and verify that their medication brought to the facility matches the Physician's Order obtained prior to	V 254		

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V 254	Continued From page 34	V 254		

arrival. The Director of Admissions will provide weekly additional training to the Admission's Assistant on this process beginning June 24, 2019.
The Case Management Department will consult the [local medical clinic] on June 21, 2019 regarding Client #2, and specifically about whether the physicians at [local clinic] feel an appointment with a cardiac specialist is needed for this client. An appointment will be scheduled for the first available date if it is determined necessary by the [local medical clinic] medical professionals.
The Case Management Department working in conjunction with the Administrative Director will review the MAR daily for medication errors and contact a pharmacist and/or physician as needed when an error takes place. Errors will be documented on the Medical Cleanup Incident report. Beginning June 24, 2019 the Administrative Director will provide weekly training to the Medical Department Case Manager and staff individuals authorized for medication administration on the procedure to obtain Physician's Orders, Standing Orders, Self-Administration Orders, and how to document medication errors and the process of contacting a pharmacist and/or physician immediately when an error takes place. This documentation will be kept in staff personnel records.
The treatment plan will be reviewed for clients showing multiple medication errors and appropriate corrective action will be put in place.
The Administrative Director met with the Program Director and Facility Assignment/Scheduling Coordinator on June 20, 2019 to discuss the treatment plans and how to document group attendance, target dates, work assignments, and a system for monitoring progression of clients as they move through the program. The Facility

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V 254	Continued From page 35 Assignment/Scheduling Coordinator met with the primary vocational partner on June 18, 2018 to address the hours clients # 3, 4, and 5 worked for the time period discussed. Client #3 has been removed from the position and the hours for clients 4 and 5 have been adjusted to ensure a balance between vocational assignment and clinical activities. The Facility Assignment/Scheduling Coordinator will take a more involved role in assessing the balance between clinical attendance and vocational training, and document the progression of each client as they move through the program. The Program Director and Facility Assignment/Scheduling Coordinator in conjunction with the Case Management Department will review the treatment plans of current clients and assess the progress of their individual treatment goals. A review of all current treatment plans will take place by July 11, 2019. Items to be reviewed will include clinical participation and the balance between vocational assignments and group attendance. Documentation of the review will be attached to the treatment plan. The Administrative Director will identify all staff in need of the Therapeutic Community specific training, including: the history, philosophy and operations of the therapeutic community, manipulative, anti-social and self-defeating behaviors, behavior modification techniques, personality traits of offenders, criminogenic behavior, the criminal justice system, understanding the nature of addiction, the withdrawal syndrome, symptoms of secondary complications to substance abuse or drug addiction, HIV/AIDS, sexually-transmitted diseases, and drug screening. The Administrative Director will ensure all staff received this training by June 27, 2019.	V 254		

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V 254	Continued From page 36 Describe your plans to make sure the above happens. The Administrative Director will work in conjunction with the Case Management Department to ensure medication errors are identified and documented on the Medical Cleanup Incident Report. The MARs will be checked at the time of each medication call as well as additional oversight by Case Management daily. The Case Management Department will ensure that a pharmacist and/or physician is contacted for each medication error. Additional training for the Medical Department Case Manager will be provided on this process. The Administrative Director will work in conjunction with the Program Director and Facility Assignment/Scheduling Coordinator to carry out a systemized approach to monitoring client treatment goals as observed in the progression of their daily activities, behaviors, clinical participation, and vocational training assignments. This process will be reflected in the client treatment plan, which will be used as a guide for clients during their time in the program." At admission Client #1 was assessed to have an identified medical condition of substantial concern that needed to be addressed. On 6/2/19 Client #1 went to the Emergency Room for edema and shortness of breath. Discharge instructions were for Client #1 to follow up with his primary care physician and see a Cardiologist to best manage his medical condition. The Medical Department Case Manager failed to arrange this follow up. On 6/15/19 and 6/16/19 Client #1 missed two doses of a medication prescribed for angina. There was no follow up with a pharmacist or physician regarding the medication errors until 6/18/19. On 6/16/19 Client #1 was seen in the Emergency Room again for chest pain, shortness	V 254		

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V 254	Continued From page 37 of breath, edema and hypertension. Client #1 was again instructed to follow up with his physician and to see a Cardiologist in 1-3 days. The Medical Department Case Manager scheduled an appointment with a local clinic but failed to schedule a cardiology appointment. Clients #2, #5, and #6 were admitted to the program and instead of completing the first phase of the program, they went right to work. Work hours continued to increase over 40 hours per week and were as high as 71 hours in a week for one client. As a result, these clients were unable to engage in their treatment. Client #5 was transported from the work site to the emergency room and evaluated for exhaustion and dehydration. Treatment plans were not individualized and failed to indicate target dates to determine completion of Phase 1 and Phase 2 of the program. Furthermore, the plans were not updated with new interventions when clients failed to meet their treatment goals. Staff were not trained in areas specific to the population that they served and there was no system in place to ensure training occurred within the required timeframes. The facility failed to follow medical recommendations and address errors in medication administration, failed to ensure clients met their therapeutic treatment goals by not addressing the demands of work, and failed to train staff. These systemic failures constitute a type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1500.00 is imposed. If the violation is not corrected within 23 days, and additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 254		

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V 256	Continued From page 38	V 256		
V 256	27G .4303 Therapeutic Community - Staff 10A NCAC 27G .4303 STAFF (a) A minimum of one staff member shall be present at all times when an adult or child is on the premises, except when an adult client has been deemed capable of remaining in the facility without supervision for a specified time by a qualified therapeutic community professional. (b) Staff-client ratios in the facilities shall be 1:30 and a minimum of one qualified therapeutic community professional shall be available for each 100 clients in a facility. (c) Each direct care staff member shall receive training in the following areas within 90 days of employment: (1) the history, philosophy and operations of the therapeutic community; (2) manipulative, anti-social and self-defeating behaviors; (3) behavior modification techniques; and (4) in programs which serve as alternatives to incarceration, training shall be received on: (A) personality traits of offenders and criminogenic behavior; and (B) the criminal justice system. (d) Each direct care staff member shall receive continuing education which shall include understanding the nature of addiction, the withdrawal syndrome, symptoms of secondary complications to substance abuse or drug addiction, HIV/AIDS, sexually-transmitted diseases, and drug screening. (e) In a facility with children and pregnant women, each direct care staff member shall receive training in: (1) developmentally-appropriate child behavior management; (2) signs and symptoms of pre-term labor;	V 256		

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V 256	Continued From page 39 (3) signs and symptoms of post-partum depression; (4) therapeutic parenting skills; (5) dynamics and needs of children and adults diagnosed as ADD/ADHD; (6) domestic violence, sexual abuse and sexual assault; (7) pregnancy, delivery and well-child care; and (8) infant feeding, including breast feeding. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 4 of 6 audited staff (House Manager, Medical Department Case Manager, Veterans Case Manager, and Admissions Assistant) were trained in the required program specific trainings for the population served. The findings are: Review on 6/17/19 of the personnel record for the Medical Department Case Manager revealed: -Date of Hire was 2/22/18. -No documentation of training in history, philosophy and operations of the therapeutic community; manipulative, anti-social and self-defeating behaviors; behavior modification techniques; personality traits of offenders and criminogenic behavior; criminal justice system; nature of addiction; withdrawal syndrome; symptoms of secondary complication to substance abuse or drug addiction; HIV/AIDS (human immunodeficiency virus), sexually-transmitted diseases, and drug screening. Review on 6/17/19 of the personnel record for the House Manager revealed:	V 256		

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FIRST AT BLUE RIDGE	32 KNOX ROAD RIDGECREST, NC 28770

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V 256	Continued From page 40 -Date of Hire was 4/26/19. -No documentation of training in nature of addiction; withdrawal syndrome; symptoms of secondary complication to substance abuse or drug addiction; HIV/AIDS (human immunodeficiency virus), sexually-transmitted diseases, and drug screening. Review on 6/17/19 of the personnel record for the Veterans Case Manager revealed: -Date of Hire was 2/25/19. -No documentation of training in history, philosophy and operations of the therapeutic community; manipulative, anti-social and self-defeating behaviors; behavior modification techniques; personality traits of offenders and criminogenic behavior; criminal justice system; nature of addiction; withdrawal syndrome; symptoms of secondary complication to substance abuse or drug addiction; HIV/AIDS (human immunodeficiency virus), sexually-transmitted diseases, and drug screening. Review on 6/20/19 of the personnel record for the Admission's Assistant revealed: -Date of Hire was 12/14/18. -No documentation of training in history, philosophy and operations of the therapeutic community; manipulative, anti-social and self-defeating behaviors; behavior modification techniques; personality traits of offenders and criminogenic behavior; criminal justice system; nature of addiction; withdrawal syndrome; symptoms of secondary complication to substance abuse or drug addiction; HIV/AIDS (human immunodeficiency virus), sexually-transmitted diseases, and drug screening.	V 256		

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V 256	Continued From page 41 Interviews on 6/12/19,6/17/19, 6/18/19 and 6/19/19 with the Administrative Director revealed: -He was responsible for scheduling training. The required trainings for therapeutic communities was usually offered once a year. He planned to schedule the identified staff for training the next time it came around. -Efforts were made to accomplish some training elements within 90 days of employment. -The identified staff had not been trained. This deficiency is cross referenced into 10A NCAC 27G .4301 Scope (254) for a Type A1 rule violation and must be corrected within 23 days.	V 256		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving	V 364		

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V 364	Continued From page 42 treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;	V 364		

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V 364	Continued From page 43 (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and	V 364		

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V 364	Continued From page 44 (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.	V 364		

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V 364	Continued From page 45 (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure clients were able to exercise the right to make and received telephone calls	V 364		

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V 364	Continued From page 46 affecting 8 of 8 current clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are: Review on 6/18/19 of the Admission Information for the Program revealed: -" ...During the first 30 days, you are allowed 1 brief phone call to family upon arrival. After preppie phase, three 15-minute phone calls to approved numbers are allowed per week ..." Record review on 6/18/19 for Client #1 revealed: -Admitted on 5/16/19 with diagnoses of alcohol use disorder, cocaine use disorder and cannabis use disorder. Record review on 6/12/19 for Client #2 revealed: -Admitted on 5/4/19 with diagnoses of alcohol use disorder, cocaine use disorder and opioid use disorder. Record review on 6/12/19 for Client #3 revealed: -Admitted on 3/28/19 with diagnoses of cocaine use disorder and amphetamine use disorder. Record review on 6/12/19 for Client #4 revealed: -Admitted on 4/4/19 with diagnoses of alcohol use disorder, opioid use disorder, amphetamine use disorder, Bi Polar Disorder, Depression, and Anxiety Disorder. Record review on 6/12/19 for Client #5 revealed: -Admitted on 4/8/19 with diagnoses of amphetamine use disorder, cannabis use disorder and opioid use disorder. Record review on 6/12/19 for Client #6 revealed: -Admitted on 3/11/19 with diagnoses of cocaine use disorder and opioid use disorder. Record review on 6/12/19 for Client #7 revealed:	V 364		

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V 364	Continued From page 47 -Admitted on 11/1/18 with diagnoses of amphetamine use disorder, attention deficit hyperactivity disorder and Anxiety Disorder. Record review on 6/12/19 for Client #8 revealed: -Admitted on 11/7/18 with diagnoses of cocaine use disorder, cannabis use disorder, and Bi Polar Disorder. Interviews on 6/12/19,6/17/19, 6/18/19 and 6/19/19 with the Administrative Director revealed: -When clients entered the program, they started in the "preppie phase". This phase lasted 30 days. -Clients could make three 15-minute calls per week after completion of the "preppie phase". -Clients signed up to use the phone. That plan was established for family calls because of their large census so that each person had an opportunity to use the phone. He did not think of their procedure as a "restriction". The 3 calls per week did not include calls to sponsors or probation officers. -Clients were never denied the opportunity to make phone calls. If a client had an emergency and needed to make a call, they were flexible and accommodating. He stated they look at it on a case by case basis. -There was no written documentation for justification for this restriction. He was not aware of that requirement.	V 364		
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	V 736		

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V 736	Continued From page 48 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: Observations on 6/6/19 at 9:55AM during the facility tour revealed: -Rusty pipes above the shower in rooms #307, #309, #310, #311, #312, #109, #110, and #113. -Peeling paint in the shower and window seal in room #412. -Missing paint in areas on shower walls and bathroom walls in room #407. -Missing paint in areas and baseboard missing in bathroom for #404. -Peeling paint on the ceiling, door damage and mirror broken for room #403. Interviews on 6/12/19,6/17/19, 6/18/19 and 6/19/19 with the Administrative Director revealed: -The facility had made several considerable improvements. -The building maintenance issues were ongoing. Maintenance was constantly addressing building upkeep.	V 736		