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V 000	INITIAL COMMENTS A limited follow up survey for the Type A1 was completed on September 20, 2019. This was a limited follow up survey, only 10A NCAC 27G .4301 Scope (V254), 10A NCAC 27G .4303 Staff (V256), 10A NCAC 27G .0209 Medication Requirements (V118), 10A NCAC 27G .0209 Medication Requirements (V123), 10A NCAC 27G .0205 Assessment and Treatment, Habilitation or Service Plan (V112), and 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209 Medication Requirements (V123) and 10A NCAC 27G .4303 Staff (V256). 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;	V 109		

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V 109	Continued From page 1 (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. (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 Professionals (Clinical Program Director) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 9/17/19 of the personnel record for the Clinical Program Director revealed: -Hired on 4/2/13. -Crendentials included Certified Clinical Supervisor, Licensed Clinical Social Worker, and Licensed Clinical Addictions Specialist. Interview on 9/16/19 with the Clinical Program Director revealed: -He supervised clinical services for the men's	V 109		

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V 109	Continued From page 2	V 109		

program.
-He reviewed the client assessments and development of the treatment plan.
-The Addiction Severity Index is the initial assessment for all clients.
-He was unable to provide any evidence that mental health services had been arranged and accessed for the identified clients.
-The focus of their program was primarily substance abuse not mental health.
-If any client needed mental health services, they were referred out to a local mental health provider.
-Treatment plans identified problem areas. Formerly, the treatment plan had included psychological as a problem area. He had removed that area to streamline the treatment plan and felt that those needs could be captured under the medical area. He indicated it was his error for removing.
-When clients entered the program there was an observation period to determine if they were experiencing Post-Acute Withdrawal Syndrome. He indicated that a lot of clients coming off drugs experienced symptoms like anxiety, mood swings or sleep issues. He indicated that if a client's mental health issues persist then a referral for mental health services would be made.
-Mental Health referrals for clients were not automatic. If a client indicated, they were struggling or if staff observed symptoms in a client then a referral would be made. Clients where the need was obvious would get referred out.
-The clients identified had not been referred to a mental health provider. He had not observed any concerning behaviors or symptoms. Staff had not reported any concerns.
-Most clients report a history of mental health issues, but referrals were not made unless the

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V 109	Continued From page 3 client presented with a need. -He was not aware that Client #2 had requested a referral for an evaluation. -Post Acute Withdrawal Syndrome was common and was hard to determine early. He stated that many times the symptoms would diminish over time once a client came off drugs and moved into a stable environment. -Making mental health referrals on the front end would be too soon. Post-Acute Withdrawal Syndrome was still common after 2 months and it took a long time for the brain to reprogram. -DPS (Department of Public Safety) clients went right to work upon entry into the program. They were in the program short term and the focus was on getting a job to become self-sufficient. This deficiency is cross referenced into 10A NCAC 27G .4301 Scope (v254) for a Failure to Correct Type A1 rule violation.	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	V 112		

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V 112	Continued From page 4 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 strategies to address the treatment needs effecting 4 of 8 audited clients (#1, #2, #3, #4). The findings are: Client #1: Record review on 9/11/19 and 9/12/19 for Client #1 revealed: -Admitted on 8/6/19 with diagnoses of alcohol use disorder, opioid use disorder and cocaine use disorder. -Addiction Severity Index assessment indicated " ...a past history of significant problems with anxiety ...has had serious problems with anxiety in the past 30 days ...experienced psychological or emotional problems on 15 of the past 30 days ...Recommendations ...He appears to have a moderately severe psychological or emotional problem, treatment is needed ..." Review on 9/11/19 of the treatment plan for Client #1 revealed:	V 112		

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V 112	Continued From page 5 -Problem areas of the treatment plan included substance use, medical, family/social, education/employment and legal. -Psychological treatment was not identified as a treatment area and there were no goals or strategies to address these needs. The treatment plan did not identify any action steps for staff to implement to assist Client #1 with his anxiety which was identified at assessment as a treatment need. Interviews on 9/12/19 and 9/16/19 with Client #1 revealed: -He indicated that he had asked about psychiatric services at the time of admission, but those services were not arranged. He had not had any discussions about mental health services. He stated that he felt that he needed treatment. Client #2: Record review on 9/12/19 for Client #2 revealed: -Admitted on 7/22/19 with diagnoses of opioid use disorder and cocaine use disorder. -Addiction Severity Index assessment indicated " ...a past history of serious problems with depression ...acknowledges a past history of significant difficulty controlling violent behavior ...Recommendations ...He appears to have a moderately severe psychological or emotional problem, treatment is needed ..." Review on 9/12/19 of the treatment plan for Client #2 revealed: -Problem areas of the treatment plan included substance use, medical, family/social, education/employment and legal. -Psychological treatment was not identified as a treatment area and there were no goals or strategies to address these needs. The	V 112		

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treatment plan did not identify any action steps for staff to implement to assist Client #2 with his depression which was identified at assessment as a treatment need.

Interview on 9/10/19 with Client #2 revealed:
-He stated that he had submitted a "Medical Proposal" to request an appointment to be evaluated for his anxiety. He wrote on the proposal that his anxiety level was "through the roof" and was in "dire need of help". He submitted the proposal on 9/4/19 and was told to wait 90 days.
-He indicated that he was still struggling with the anxiety but that he exercised a lot and that had helped.

Client #3:

Record review on 9/12/19 for Client #3 revealed:
-Admitted on 7/22/19 with diagnoses of opioid use disorder, sedative use disorder, amphetamine use disorder, Major Depressive disorder, and Post Traumatic Stress Disorder.
-Addiction Severity Index assessment indicated " ...a past history of psychiatric symptoms ...including serious problems with depression and anxiety ...past history of difficulty understanding and concentrating, as well as trouble controlling violent behavior ...has a history of one inpatient treatment for psychological problems, and one episode of outpatient treatment ...has had serious problems with depression in the past 30 days ...has had serious problems with anxiety in the past 30 days ...experienced symptoms on 30 of the past 30 days, and is profoundly bothered by them. Obtaining psychological or emotional treatment is of profound importance to him ...Recommendations ...has a psychological or emotional problem of substantial concern and

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V 112	Continued From page 7 help obtaining appropriate treatment is necessary at this time ..." Review on 9/12/19 of the treatment plan for Client #3 revealed: -Problem areas of the treatment plan included substance use, medical, family/social, education/employment and legal. -Psychological treatment was not identified as a treatment area and there were no goals or strategies to address these needs. The treatment plan did not identify any action steps for staff to implement to assist Client #1 with his anxiety which was identified at assessment as a treatment need. Interviews on 9/10/19 and 9/12/19 with Client #3 revealed: -He had received mental health treatment in the past but had quit going. -He saw a family nurse practitioner at the medical practice that prescribed his Suboxone. He believed that she worked with him around his depression and anxiety. He had not seen her in 2 months. Client #4: Record review on 9/10/19 for Client #4 revealed: -Admitted on 8/22/19 with diagnoses of sedative use disorder and cannabis use disorder. -Addiction Severity Index assessment indicated " ...a past history of psychiatric symptoms ...including serious problems with depression and anxiety ... past history of difficulty understanding or concentrating ...has been prescribed medications for psychological difficulties ... has a history of one inpatient treatment for psychological problems, and one episode of outpatient treatment ... has had serious problems	V 112		

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with anxiety in the past 30 days ...has been prescribed psychotropic medications in the past 30 days ...experienced symptoms on 30 of the past 30 days and is bothered considerably by them. Obtaining psychological or emotional treatment is of profound importance to him ...Recommendations ...He appears to have a moderately severe psychological or emotional problem, treatment is needed ..."

Review on 9/10/19 of the treatment plan for Client #4 revealed:
-Problem areas of the treatment plan included substance use, medical, family/social, education/employment and legal.
-Psychological treatment was not identified as a treatment area and there were no goals or strategies to address these needs. The treatment plan did not identify any action steps for staff to implement to assist Client #4 with his anxiety which was identified at assessment as a treatment need.

Client #4 was discharged from the facility prior to the conclusion of the survey and could not be interviewed specifically about this treatment area.

See Tag V109 for additional information.

Interviews on 9/12/19 and 9/16/19 with the Administrative Director revealed:
-They made referrals to outside agencies for mental health services. Treatment team members would make the decision for a client to be referred out. All clients were monitored during the first 30 days of the program for progress and to determine if any mental health symptoms were present. If indicators were present, they would bring the client in to discuss.
-The Addiction Severity Index was completed by a

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V 112	Continued From page 9 clinical team member. -Any treatment area identified in the ASI assessment should make it into the treatment plan. -At the time of the assessment clients were instructed that if symptoms persist then they needed to meet with the team to discuss a referral to a mental health provider. They let the clients know if the mental health provider recommended more intensive services (i.e. Intensive Outpatient Program) that met multiple times per week that it could affect their stay at the facility. He indicated following that discussion some clients would change their mind about treatment. If the client continued to persist then a referral would be made. -The clinical director was ultimately responsible for ensuring that mental health needs were met. This deficiency is cross referenced into 10A NCAC 27G .4301 Scope (v254) for a Failure to Correct Type A1 rule violation.	V 112		
V 118	27G .0209 (C) Medication Requirements 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	V 118		

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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 record review and interviews the facility failed to ensure that all medications administered were ordered by a person authorized by law to prescribe drugs, and failed to ensure MARs were current for 6 of 8 audited clients (#1, #2, #3, #4, #5, #8) and 1 of 1 Qualified Professionals (Medication Case Manager) failed to demonstrate competency in the administration of medications. The findings are:

Client #1:

Record review on 9/11/19 and 9/12/19 for Client #1 revealed:
-Admitted on 8/6/19 with diagnoses of alcohol use disorder, opioid use disorder and cocaine use disorder.
-The medication order for Quetiapine 300mg

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(miligram) (anti-psychotic), one at bedtime, was signed by an LPN (Licensed Practical Nurse) on 7/31/19. The physician never signed the order.
-The order to self-administer medications had also been signed by the LPN on 7/31/19. The physician did not sign the self-administration order.
-Physician's order dated 8/19/19 for Bactroban ointment, apply daily.

Review on 9/10/19 of the August 2019 and September 2019 MARs for Client #1 revealed:
-Bactroban not added to the MARs in August or September.
-Self-administration of medications began following admission.

Interview on 9/12/19 with Client #1 revealed that he self-administered his Quetiapine daily.

Client #2:

Record review on 9/12/19 for Client #2 revealed:
-Admitted on 7/22/19 with diagnoses of opioid use disorder and cocaine use disorder.
-Physician's order dated 9/1/19 for Penicillin (antibiotic) 500mg, 1 four times daily for 7 days.
-Physician's order dated 9/1/19 for Ibuprofen (anti-inflammatory) 800 mg, 1 three times daily as needed.

Review on 9/10/19 of the September 2019 MARs for Client #2 revealed:
-Administration of the Penicillin did not begin until 9/3/19, two days following the written order.

Interview on 9/10/19 with Client #2 revealed:
-He indicated that he had gone to the emergency room for tooth pain. He was prescribed Ibuprofen (as needed) and Penicillin. He stated there was a

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V 118	Continued From page 12 2-day delay in getting the medications. He indicated that his pain level was a 6 or 7 out of 10. Client #3: Record review on 9/12/19 for Client #3 revealed: -Admitted on 7/22/19 with diagnoses of opioid use disorder, sedative use disorder, amphetamine use disorder, Major Depressive disorder, and Post Traumatic Stress Disorder. -Physician's order dated 7/12/19 for Suboxone (for addiction) 16mg daily. The order was reduced to 12mg on 8/19/19. Review on 9/10/19 of the August 2019 and September 2019 MARs for Client #3 revealed: -The August and September MARs did not indicate the dose reduction for Suboxone. Interviews on 9/10/19 and 9/12/19 with Client #3 revealed: -He self-administered his Suboxone. He saw a clinician at a local medical provider monthly about the Suboxone. This practice prescribed the Suboxone and conducted urine drug testing. -He confirmed that his dose of Suboxone had been reduced. Client #4: Record review on 9/10/19 for Client #4 revealed: -Admitted on 8/22/19 with diagnoses of sedative use disorder and cannabis use disorder. -Physician's order dated 8/26/19 for Fluoxetine (depression) 40mg, 2 daily. -Physician's order dated 8/26/19 for Mirtazapine (depression) 15mg, one at bedtime. -These orders were obtained 4 days following admission.	V 118		

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V 118	Continued From page 13 -No signed self-administration order. Review on 9/10/19 of the August 2019 and September 2019 MARs for Client #4 revealed: -Self Administration of the Fluoxetine and Mirtazapine began on 8/22/19 the day of admission. Interview on 9/10/19 with Client #4 revealed that he had self-administered his medications since admission and that he met with a medical provider following admission. Client #5: Record review on 9/10/19 for Client #5 revealed: -Admitted on 8/21/19 with diagnoses of alcohol use disorder and cocaine use disorder. -Physician's orders dated 8/26/19 for Metformin (diabetes) 500mg, 2 twice daily, and Cyclobenzaprine (muscle spasms)10mg, 1 every 8 hours as needed. These orders were obtained 5 days following admission. -There was no physician's order for self-administration. Review on 9/10/19 of the August 2019 and September 2019 MARs for Client #5 revealed: -Self-administration of the Metformin and Cyclobenzaprine started on 8/21/19. Interview on 9/12/19 with Client #5 revealed that he self-administered his medications daily. Client #8: Record review on 9/16/19 for Client #8 revealed: -Admitted on 5/16/19 with diagnoses of alcohol use disorder, cocaine use disorder, and cannabis use disorder.	V 118		

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V 118	Continued From page 14 -Physician's order dated 6/18/19 for Albuterol Inhaler, inhale 2 puffs four times daily. -Physician's order dated 6/18/19 to check blood pressure and pulse and keep record twice daily. No order to discontinue blood pressure or pulse readings. The "Patient Service Form" dated 6/18/19 completed by the physician at the local medical clinic indicated " ...hypertension poor control ...". -Blood pressure and pulse were recorded twice daily on 6/19/19-6/22/19, 6/24/19, 6/25/19 and once on 6/26/19. There were no further readings after 6/26/19. Review on 9/10/19 of the July 2019, August 2019 and September 2019 MARs for Client #8 revealed: -Albuterol was not included on the MARs for July-September. Interview on 9/16/19 with Client #8 revealed: -He used his inhaler every four hours. He kept the inhaler with him. -The physician had told him to check his blood pressures and pulse because of a change in his blood pressure medications. The doctor wanted to make sure the medication change was effective. -He saw a Cardiologist for a stress test and following that test he stopped checking his blood pressures and pulse. His stress test was normal. The facility had provided him the equipment to check his own blood pressures and pulse. Interview on 9/10/19 with the Director of Programming for Pre-trial revealed: -Prior to the admission of Client #1 she had spoken to the county jail nurse about his medications. This nurse indicated that she reviewed all cases with the overseeing Physician.	V 118		

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V 118	Continued From page 15 She had reviewed the Quetiapine order for Client #1 with the physician and he had given her authorization to sign the order for him. Client #1 left the county jail with the medication. -The jail nurse indicated that the doctor was only on site for acute medical cases. Interviews on 9/12/19 and 9/16/19 with the Medical Case Manager revealed: -She was not a nurse and had no medical training. -DPS (Department of Public Safety) clients were taken to a local medical clinic as soon as possible following admission. The physician of the clinic had agreed to medically assess the clients and write prescriptions for any medications they were taking. This physician would not, however, sign orders to self-administer medications or sign the order for over the counter medications. It was a walk-in clinic only open Monday through Wednesday. Any DPS clients admitted on a Thursday or Friday could not be seen until the following week. -Once clients were seen initially at the local medical clinic then they were scheduled with a local primary care provider (PCP). This PCP would then sign for self-administration and over the counter medications. It could take 1-1 1/2 months to get an appointment with the primary care provider. -She indicated they have no control over how fast a client can be seen by the primary care provider. -Client #4 was admitted on a Thursday and they could not get medication orders until the following Monday. -Client #5 was admitted on a Wednesday and was not taken to the clinic until the following Monday. -Client #2 went to the emergency room on a Sunday for his tooth pain. She indicated that	V 118		

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V 118	Continued From page 16 9/2/19 was a holiday and therefore the prescriptions he needed were not obtained until 9/3/19. She was unaware as to why the prescriptions had not been obtained at the hospital pharmacy or from their local pharmacy on 9/2/19. -She reviewed MARs daily and was responsible for updating the MARs when medications changed. -Failure to revise the MAR for Client #3 when his medication dose changed was an oversight. -Client #8 was having high blood pressure when he was seen in the emergency room on 6/16/19. The blood pressure and pulse checks were ordered on 6/18/19 when he had a follow up visit after going to the emergency room. The blood pressure checks, and pulse rate checks were conducted in the medication room in the presence of a staff member. Client #8 then went to see a Cardiologist on 6/28/19 for a stress test. The results were normal. After he had normal test results, he stopped taking his blood pressures and pulse. She felt that he no longer needed to do that because his cardiac test results were good. She did not follow up with the medical provider about the original order to monitor blood pressure and pulse. She did not obtain an order to discontinue those checks. Client #8 had not seen another medical provider since his stress test. Interviews on 9/12/19 and 9/16/19 with the Administrative Director revealed: -DPS (Department of Public Safety) clients did not go through the regular intake process. -Admissions for DPS clients were arranged by probation officers working with the Program Services Department or by a prison case manager working with the same department. Admissions occurred very quickly, sometimes the	V 118		

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V 118	Continued From page 17	V 118		

same day or next day but always within 5 days.
-The facility did not usually know about a client's medications until arrival. Clients arrived with medications but no physician orders. Their procedure was to take the client to a local medical clinic as soon as possible following admission. He stated this procedure was faster than dealing with the DPS system.
-He had spoken to a representative for DPS and explained their need for physician orders. He indicated that DPS understood the licensure requirement, but they were unable to come to a resolution.
-He felt that the facility had done all they could to obtain physician's orders for DPS clients prior to admission.
-DPS was a significant funding source for their program.

Review on 9/17/19 of the plan of protection completed and signed on 9/17/19 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 clinic] in [town] on 6/12/19 to discuss referring clients without Physician's orders to [local clinic] as a bridge until the client's primary care physician can be established at the [Local Health Center] or other area provider. [Local clinic] agreed to serve in this capacity. [Local clinic] agreed to see our clients and address medication refills providing Physician's orders until individual clients have acquired primary care.

FIRST will administer medication for clients without a self-administration order until that order is obtained at [Local Health Center] or a primary

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V 118	Continued From page 18 care provider. FIRST contacted the NCDPS (North Carolina Department of Public Safety) Program Services Office on 9/17/19 calling for a meeting regarding Physician's Orders and other documents needed for clients entering the program. At this meeting FIRST will convey the importance of obtaining medical orders for clients prior to their arrival at FIRST. FIRST will work in conjunction with Program Services to receive orders prior to the client's arrival. FIRST's Case Management Department will identify all clients in need of Physician's orders and schedule appointments accordingly. This identificatin and scheduling process will take place on an ongoing basis and will be monitored Case Management supervised by the Administrative Director. FIRST's Case Management Department will identify documentation errors on the client MAR and review the MAR daily for accuracy and compliance. This includes ensuring the MAR is properly dated, reflects any medication changes or administration updates, and that the MAR contains all client medications. Until a meeting with the NCDPS Program Services Office can be established, FIRST will communicate the need to accept referrals on Monday, Tuesday and Wednesday for DPS clients taking medication. This will allow for the procurement of appropriate medical orders for clients on medication by utilizing [local clinic] on the day of the client's arrival. FIRST will pursue the possibility of a Staff medical presence and collaboration with Urgent Care facilities, [local hospital] and other community organizations for	V 118		

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V 118	Continued From page 19 clients to obtain medical paperwork. The Administrative Director will provide training for the Medical Case Manager. Training will include oversight on reviewing the MAR for accuracy, documentation errors, and ensuring the MAR is properly dated, reflects any medication changes and administration updates, that it contains all client medications, and matches the Physician's Orders. The Administrative Director will review all medical orders with the Medical Department Case Manager, including blood pressure and pulse orders, and the process for following them." "Describe your plans to make sure the above happens. FIRST's Director of Admissions will ensure that program applicants have Physician 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 clinic] are scheduled for DPS 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 health center] or other area provider. FIRST will utilize [local clinic] as a bridge until the primary care appointment is	V 118		

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V 118	Continued From page 20 attended. FIRST will utilize [local hospital's] Emergency Department should a situation arise where a client is unable to obtain Physician's Orders by this process." Client #8 has a history of hypertension and is prescribed multiple medications for the treatment of this condition. On 6/18/19 the physician noted that Client #8's hypertension was poorly controlled and ordered medication changes as well as ordered blood pressure and pulse readings to be taken and recorded twice daily. Blood Pressures and pulse recordings were conducted and recorded until 6/26/19. The Medication Case Manager felt that blood pressures and pulse readings were no longer necessary after Client #8 had a cardiac stress test that was normal. There was no follow up with a physician to determine if blood pressures and pulse readings needed to continue or could be discontinued. Additionally, the facility has failed to establish and maintain a system to ensure that physician orders for medication and self-administration are in place when clients enter the program. Clients #1, #2 and #4 were taking medications to treat medical and mental health conditions. The facility has also failed to maintain a system of checks and balances that ensured MARs were current and accurate and reflected changes to medications as they occurred. There was also no system that ensured prompt delivery of medications to clients when ordered for treatment. These systemic failures constitute a failure to correct the Type A1 rule violation originally cited for serious harm and neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	V 118		

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V 254	Continued From page 21	V 254		
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. (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).	V 254		

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V 254	Continued From page 22 This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to meet client needs in psychological areas, effecting 4 of 8 audited clients (#1, #2, #3, #4). The findings are: Cross reference: 10A NCAC 27G .0203 Competencies of Associate Professionals and Qualified Professionals (V109) Based on record reviews and interviews, 1 of 1 Qualified Professionals (Program Director Men's Program) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or 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 4 of 8 audited clients (#1, #2, #3, #4). Review on 9/17/19 and 9/20/19 of the plan of protection completed and signed on 9/17/19 and then again on 9/20/19 following a revision 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 Program Director revised the Client Treatment Plan on 9/16/2019 to include the following for medical/psychological concerns: 1. Take medication as directed, if applicable. 2. Attend medical appointments, if applicable. 3. Attend mental health appointments, if applicable. 4. Report to staff any symptoms of depression, anxiety, hopelessness, mania, etc.	V 254		

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V 254	Continued From page 23 5. IF SYMPTOMS WORSEN, TELL STAFF IMEDIATELY. FIRST's Program Director and Counselor reviewed the ASI Assessments for current clients on 9/17/2019 and identified those where psychological and/or mental health concerns were noted. FIRST will utilize the Staff Clinical Director primarily assigned for the Women's Facility and or other Qualified Professional to meet with these clients regarding their current psychological state. The Clinical Director and/or Qualified Professional will update the treatment plan as necessary in accordance to the plan detailed below. The Program Director and Counselor will conduct the ASI Assessment for new admissions passing the completed Assessment to the Clinical Director and/or Qualified Professional to draw a treatment plan. Psychological concerns, or substance use, family/social, education/employment, and legal concerns will be reviewed monthly based on interacting and observing the client and their participation in the program. The Program Director will receive competency training from the Clinical Director primarily assigned to the Women's Facility. The training will include examining the process building a treatment plan and reviewing it regularly in regard to the client concerns entailed. The Clinical Director primarily assigned to the Women's Facility will serve in interim in this way until the Program Director's competencies are considered in compliance." "Describe your plans to make sure the above happens. FIRST's Program Director, Director of Admissions, Administrative Director, and Clinical Director primarily assigned to the Women's Facility will comprise the clinical team. The team	V 254		

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V 254	Continued From page 24 will communicate weekly regarding any client psychological or mental health concerns reported, substance use, family/social, education/employment, legal, or other target area reflected in the treatment plan. Areas of communication will be centered on client behaviors, participation in the program, groups and meetings, and situations where the client is acting outside of what is agreed upon with staff as an individual goal and objective when the service plan is created. The Clinical Director primarily assigned to the Women's Facility and/or Qualified Professional will review the client treatment plan monthly to follow up on noted goals and objectives and concerns. The Clinical Director primarily assigned to the Women's Facility and/or Qualified Professional will review the ASI Assessments for new clients and create the initial treatment plan based on information therein. The process and action steps for assisting clients with psychological and/or mental health concerns is as follows: -Staff will facilitate a meeting for the client with an internal counselor in instances where psychological needs are noted on the ASI. Clients will receive instruction on how to submit proposals to address psychological care during this meeting. -Staff will facilitate a meeting for the client with an internal counselor in instances where Staff observes client psychological or mental health needs, or if there is reason to believe these needs are present and the client has not submitted a proposal. -The Clinical Team will convene in such circumstances to determine the proper course of action. Possible courses of action include: -Continued meeting with the internal counselor for a specified period of time.	V 254		

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V 254	Continued From page 25 -Referral to outside mental health agency. -Discharge from the program if it is determined the mental health/psychological concern is greater than what can be accommodated for at FIRST. The process and action steps for clients and staff regarding creating and following up on the goals and objectives for substance use, family/social, education/employment, legal, and other target areas noted on the treatment plan are as follows: -The Admission's Department will conduct a pre-assessment and phone interview with client applicants pre-admission to the program. -The Clinical Staff will conduct an initial assessment post admission addressing the client's history of substance use. -The Clinical Department, as directed by the Clinical Director primarily assigned to the Women's Facility, will create a goal-oriented client service plan that encompasses the substance use, family/social, education/employment, psychological, legal, and any other target areas noted between the pre-assessment and initial assessment. -The goal-oriented objectives will be documented and reflected in the service plan, which will be reviewed by the comprised Clinical Team and client regularly based on client behaviors, participation in the program, groups and meetings, House Manager reports, and situations where the client is acting outside of what is agreed upon with staff as an individual goal and objective when the initial plan is created. The following action steps will be implemented if it is determined by the Clinical Team the client is in need of intervention: -Staff will facilitate a meeting for the client with an internal counselor and/or house manager. Staff will provide clients with instruction on how to	V 254		

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V 254	Continued From page 26	V 254		

submit proposals to address the target areas of their concern.
-The Clinical Team will review the outcomes of such a meeting and determine the proper course of action. Possible courses of action include:
-Continued meeting with the internal counselor and/or house manager for a specified period of time.
-Referral to outside agency when necessary.
-Discharge from the program if it is determined the concern is greater than what can be accommodated for at FIRST.

Four clients were admitted into the program and assessed to have psychological conditions such as anxiety and/or depression. Upon assessment it was determined that mental health treatment was needed for these clients, however, the facility failed to address these needs. The Clinical Director failed to ensure these needs were addressed in the treatment plan. There was no follow up with these clients following admission to determine if their mental health condition identified at the time of assessment continued to cause them distress. There was no system in place to identify if clients were experiencing Post-Acute Withdrawal Syndrome as opposed to ongoing symptoms of a mental health disorder. There were no referrals to local mental health agencies. Client #3 requested follow up with a mental health provider, but that referral was not made. The facility has failed to establish and maintain and system to individualize treatment planning that included goals and specific staff interventions to address the comprehensive needs of the clients that they serve. These failures constitute a Failure to Correct a Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST AT BLUE RIDGE	32 KNOX ROAD RIDGECREST, NC 28770

(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 254	Continued From page 27 within 23 days.	V 254		