Division of Health Service Regulation

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE COMPI		SURVEY PLETED			
			A. BUILDING:			₹
		MHL096-186	B. WING			23/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CAROLII	NA TREATMENT CEN	HER OF GOLDSB	ST ASH STRE ORO, NC 27	ET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS	V 000			
	completed on Octo	int and follow up survey was ber 23, 2019. The complaint (intake #NC00156184). cited.				
		sed for the following service C 27G .3600 Outpatient Opioid				
	The census at the	time of the survey was 215.				
V 131	G.S. 131E-256 (D2 Verification	2) HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring health care facility health care facility Personnel Registry	ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.				
	Based on record refacility failed to ensing Personnel Registry to hire affecting 2 of #3/Licensed Clinical Specialist-Register #5/Licensed Clinical findings are:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPI	SURVEY LETED
					R	
		MHL096-186	B. WING			3/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAROLII	NA TREATMENT CEN	TER OF GOLDSB	T ASH STRE DRO, NC 27	ET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 131	completed. Review on 10/23/19 record revealed: -Date of hire was 10-Position was a cou-No documentation completed. Interview on 10/23/ revealed: -She was not able to the HCPRs had been LCAS-R/Staff #3 arreshe would ensure	evealed: 0/23/19. Inselor. The HCPR had been 0/22/19. Inselor. The HCPR had been 0/22/19. Inselor. The HCPR had been 19 the Clinical Director o locate any documentation	V 131			
V 133	G.S. §122C-80 CRI CHECK REQUIREI APPLICANTS FOR (a) Definition As a "provider" applies to program and any provider licensed unapplicant to fill a porogram applicant to have an conditioned on conscriminal history recommendation.		V 133			

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STATE FORM 6899 TORO11 If continuation sheet 2 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED	
						R	
		MHL096-186	B. WING		10/2	3/2019	
NAME OF PROVIDER OR SU	PPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CAROLINA IREALMENT CENTER OF GOLDSB			T ASH STRE DRO, NC 27	EET, SUITE 200, 201, 202 & 300 530			
PREFIX (EACH DEF	ICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
is conditione criminal histornational criminal histornational criminal histornational criminal five years or on consent to check of the employ an approximal histornation of the conditions shall submit Justice under criminal histornation or check required G.S. 114-19. Teturn the respective covered by F. Department of Criminal Recommendation of the application of the application of the applicational criminal	e years d on cory rec inal his eck of has b more, o a Sta applica ory rec ept as within f al offe a requ r G.S. ory rec all sub duct a for Hea cords (or perso Service tify the eceive ant. In inal his ider. F t verifi een co on. A c	inge 2 s, then the offer of employment consent to a State and national ord check of the applicant. The story record check shall the applicant's fingerprints. If een a resident of this State for then the offer is conditioned atte criminal history record ant. A provider shall not at who refuses to consent to a ord check required by this otherwise provided in this ive business days of making r of employment, a provider est to the Department of 114-19.10 to conduct a ord check required by this omit a request to a private State criminal history record his section. Notwithstanding a Department of Justice shall f national criminal history employment positions not caw 105-277 to the lith and Human Services, check Unit. Within five except of the national criminal and, the Department of Health est, Criminal Records Check exprovider as to whether the d may affect the employability no case shall the results of the story record check be shared through the story record check be shared through the story record check be shared through the story record check and the story r	V 133				

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
						R	
		MHL096-186	B. WING		10/2	3/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
045011	LA TOCATACNE OCN	1700 EAS	T ASH STRE	ET, SUITE 200, 201, 202 & 300			
CAROLII	NA TREATMENT CEN	TER OF GOLDSB	ORO, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 133	Continued From pa	age 3	V 133				
V 133	may conduct on be criminal history recesection without the request to the Depacase, the county shoriminal history recesection within five to conditional offer of All criminal history in provider is confider except to the application of the conditional history recesection, the term business regularly criminal history recesered obtained from the following fact hire the applicant: (1) The level and section of the conviction. (2) The date of the conviction. (3) The age of the proposition of the conviction. (4) The circumstance of the preson and the filled. (6) The prison, jail, rehabilitation, and experson since the day of the subsequent a relevant offense.	chalf of a provider a State ord check required by this provider having to submit a cartment of Justice. In such a hall commence with the State ord check required by this business days of the employment by the provider. Information received by the employment by the provider. Information received by the otial and may not be disclosed, cant as provided in subsection for purposes of this m "private entity" means a engaged in conducting ord checks utilizing public om a State agency. Opplicant's criminal history also one or more convictions of the provider shall consider all tors in determining whether to deriousness of the crime. Operson at the time of the crime, if known. Ween the criminal conduct of job duties of the position to be	V 133				
	shall not be a bar to listed factors shall be	o employment; however, the be considered by the provider. ualifies an applicant after					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL096-186	B. WING		F 10/2	R 23/2019
CAROLINA TREATMENT CENTER OF GOLDSB				STATE, ZIP CODE SET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	consideration of the provider may disclothe criminal history to the disqualification of the criminal history to the disqualification of the criminal history applicant. (d) Limited Immunition or employee of a promplies with this scivil liability for: (1) The failure of the individual on the bathe criminal history (2) Failure to check criminal offenses if history record check criminal offenses if history record check criminal offenses in federal criminal history relevant offense relevant offense indictment of a criminal history persons needing musicabilities, or subscrimes include the cany of the following General Statutes: A Issuing Monetary Sendangering Executarticle 6, Homicide; Sex Offenses; Artick Kidnapping and Abulnjury or Damage be Incendiary Device of and Other Housebrother Burnings; Art Robbery; Article 18	e relevant factors, then the se information contained in record check that is relevant on, but may not provide a copy ry record check to the y A provider and an officer ovider that, in good faith, ection shall be immune from e provider to employ an sis of information provided in record check of the individual. an employee's history of the employee's criminal k is requested and received in				

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER CAROLINA TREATMENT CENTER OF GOLDSB (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 133 Continued From page 5 MHL096-186 STREET ADDRESS, CITY, STATE, ZIP CODE 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NC 27530 (X4) ID PROVIDER'S PLAN OF CORRECTION FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 133 Continued From page 5	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER CAROLINA TREATMENT CENTER OF GOLDSB (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPANY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OAT		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE DEFICIENCY) (X5) DATE OF COMPANDED TO THE APPROPRIATE DEFICIENCY)	NAME OF PROVIDER OR SUPPLI	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DATE DEFICIENCY)	CAROLINA TREATMENT C	
V 133 Continued From page 5 V 133	PREFIX (EACH DEFICIE	
Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 28A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family, Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check under this section from the conditional prior to obtaining the applicant of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in Gs. 114-19-10. (2) The provider shall not employ and completed fingerprint cards as required in Gs. 114-19-10.	Obtaining Proper Fraudulent Use Article 19B, Fina Act; Article 20, F 26, Offenses Ag Decency; Article Article 27, Prost 29, Bribery; Article Office; Article 38, Peace; Article 39, Prote Protection of the Intoxication; and Crime. These or sale of drugs in Controlled Subs 90 of the General offenses such as violation of G.S. impaired in viola G.S. 20-138.5. (f) Penalty for Full applicant for em supplies, or other an employment criminal history is shall be guilty of (g) Conditional Elemploy an applic obtaining the rescheck regarding following requires (1) The provider prior to obtaining criminal history is subsection (b) of fingerprint cards (2) The provider	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUILDING.		R	
		MHL096-186	B. WING		10/23/2	2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAROLII	NA TREATMENT CEN	TER OF GOLDSB	T ASH STRE DRO, NC 27	EET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE C	(X5) COMPLETE DATE
V 133	business days after conditional employs 2001-155, s. 1; 200 2005-4, ss. 1, 2, 3,	r the individual begins ment. (2000-154, s. 4; 04-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.) et as evidenced by:	V 133			
	Based on record refailed to provide do background checks (staff #3/Licensed (Specialist-Register #5/LCAS-R). The final Review on 10/23/19	eviews and interview the facility ocumentation of a criminal is for two of four audited staff Clinical Addiction ed (LCAS-R) and staff findings are: 9 of staff #3's/LCAS-R				
	personnel record re -Hire date of 10/23 - No documentation check.					
	personnel record re - Hire date of 10/22					
	stated: -She was new to the hired new staff due work for another trearea.	n 10/23/19 the Clinical Director are current position and had to the prior staff having left to eatment facility in the local as sar required.				

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AND DUAN OF CORRECTION IN IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED		
		MHL096-186	B. WII	NG			R 23/2019
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS,	CITY, ST	ATE, ZIP CODE		
CAROLII	NA TREATMENT CEN	TER OF GOLDSB	1700 EAST ASH GOLDSBORO, N		ET, SUITE 200, 201, 202 & 30 30	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL PRE	D EFIX AG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 233	Continued From pa	ige 7	V 23	3			
V 233	27G .3601 Outpt. C	piod Tx Scope	V 23	3			
	provides periodic sindividual an oppor changes in his lifes other medications a treatment in conjunt rehabilitation and m (b) Methadone and for use in opioid tredetoxification and mopioid dependent in (c) For the purpose and other medication treatment shall be a doses for a period (d) For individuals physiologically additionate and other medication in opioid treatment and other use in opioid treatment methadone and other methadone and other use in opioid treatmethadone and other us	pioid treatment facility ervices designed to contunity to effect constraintyle by using methad approved for use in oution with the provisionedical services. If other medications a catment are also tools ehabilitation process.	offer the uctive one or pioid on of approved in the of an ethadone ein opioid easing ys. g g for at service, oved for et d in , oved for tered or nall be				
	Based on record re facility failed to provaffect constructive by using methadon provision of rehabil	et as evidenced by: views and interviews vide services designe changes in the client' e in conjunction with itation and medical s ents(#11247, #11452	ed to 's lifestyle the ervices				

Division of Health Service Regulation

STATE FORM 6899 TORO11 If continuation sheet 8 of 20

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL096-186	B. WING			R 10/23/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/2	0/2010	
	NA TREATMENT CEN	TER OF GOLDSB 1700 EAS	T ASH STRE	EET, SUITE 200, 201, 202 & 300			
0(4) ID	CHMMADV CTA		ORO, NC 27		ON!	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 233	Continued From pa	ige 8	V 233				
	#11332). The finding	ngs are:					
	revealed: - 43 year old female - Admission date of - Diagnosis of Opio - No counselor note positive Urine Drug addressed. Review on 10/23/19 orders and UDS rev 08/13/19 - Client #11247 was to 145 milligrams(mamphetamine (stim	f 07/09/18. did Use Disorder-Severe. es to indicate the client's Screen (UDS) was 9 of client #11247's physician vealed: s decreased Methadone dose ng) due to a positive UDS for					
	resume 4 take home Interview on 10/23/ - She had received more than one year - She did not have a - She had attended facility. B. Review on 10/23	s approved by the physician to ne doses of Methadone. 19 client #11247 stated: services at the facility for r. a current counselor. some group meetings at the					
	- No counselor note positive UDS's.						

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STATE FORM 6899 TORO11 If continuation sheet 9 of 20

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MHL096-186 STREET ADDRESS, CITY, STATE, ZIP CODE 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORO, NO. 27530 1700	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER CAROLINA TREATMENT CENTER OF GOLDS (X4) ID PREFIX (SUMMARY STATEMENT OF DEFICIENCY STATE) SUPPLIED (SUMMARY STATEMENT OF DEFICIENCY STATE) PROVIDER PLAY OF CORRECTION (SCHOOLDS) PROVIDER PLAY OF CORRECTION SHOULD BE PRECEDED BY FULL REGULATION FOR INFORMATION) V 233 Continued From page 9 results revealed: - 07/22/19-positive for THC 08/16/19-positive for THC 08/16/19-positive for THC 10/14/19-positive for THC 10/14/19-positive for THC 10/19. Union Drug Screens: On 07/31/19 ShowsTHC+ (positive)Plan: Pt. (patient) advised to fu (follow up) with the counselor for UDS' Interview on 10/23/19 client #11452 stated: - She had not seen a counselor since her admission. C. Review on 10/22/19 of client #11332's record revealed: - 39 year old male Admission date of 05/24/19 Diagnosis of Opioid Use Disorder-Severe No counselor notes from 08/19 and 09/19 to address positive UDS's. Review on 10/22/19 revealed: - 08/13/19 through/13/19 revealed: - 39/31/19 through/13/19 revealed: - 39 year old male Admission rotes from 08/19 and 09/19 to address positive UDS's. Review on 10/22/19 of client #11332's UDS from 08/13/19 through/13/19 revealed: - 08/13/19 through/13/19 revealed: - 08/13/19-positive for Fentanyl (opiate) 08/13/19-positive Amphetamine and Fentanyl.							
ACADOLINA TREATMENT CENTER OF GOLDSB 1700 EAST ASH STREET, SUITE 200, 201, 202 & 300 GOLDSBORD, NC 27530			MHL096-186	B. WING		10/2	3/2019
CANCIDIAN FRAMENT CENTER OF GOLDSS CANCIDIAN CAN	NAME OF I	PROVIDER OR SUPPLIER			,		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 233 Continued From page 9 results revealed: - 07/22/19-positive for Tetrahydrocannabinol (THC) 08/16/19-positive for THC 08/16/19-positive for THC 10/14/19-positive for THC. Review on 10/23/19 of an unsigned case note for client #11452 revealed: - "30 Day Follow Up - Date of Admission: On 07/10/19. Urine Drug Screens: On 07/31/19 ShowsTHC+ (positive)Plan: Pt. (patient) advised to f/u (follow up) with the counselor for UDS" Interview on 10/23/19 client #11452 stated: - She had not seen a counselor since her admission. C. Review on 10/22/19 of client #11332's record revealed: - 39 year old male Admission date of 05/24/19 Diagnosis of Opioid Use Disorder-Severe No counselor notes from 08/19 and 09/19 to address positive UDS's. Review on 10/22/19 of client #11332's UDS from 08/13/19 thru 09/13/19 revealed: - 08/13/19-positive for Fentanyl (opiate) 09/13/19-positive Amphetamine and Fentanyl.	CAROLINA IREALMENT CENTER OF GOLDSB						
results revealed: - 07/22/19-positive for Tetrahydrocannabinol (THC). - 07/31/19-positive for THC 08/16/19-positive for THC 09/09/19-positive for THC 10/14/19-positive for THC 10/14/19-positive for THC 10/14/19-positive for THC. Review on 10/23/19 of an unsigned case note for client #11452 revealed: - "30 Day Follow Up - Date of Admission: On 07/10/19. Urine Drug Screens: On 07/31/19 ShowsTHC+ (postitive)Plan: Pt. (patient) advised to f/u (follow up) with the counselor for UDS" Interview on 10/23/19 client #11452 stated: - She had received services at the facility for approximately 4 months She had not seen a counselor since her admission. C. Review on 10/22/19 of client #11332's record revealed: - 39 year old male Admission date of 05/24/19 Diagnosis of Opioid Use Disorder-Severe No counselor notes from 08/19 and 09/19 to address positive UDS's. Review on 10/22/19 or client #11332's UDS from 08/13/19 thru 09/13/19 revealed: - 08/13/19- positive for Fentanyl (opiate) 09/13/19-positive Amphetamine and Fentanyl.	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
stated: - She started at the facility on 08/26/19 All the previous counselors had left the facility.	V 233	results revealed: - 07/22/19-positive (THC) 07/31/19-positive - 08/16/19-positive - 09/09/19-positive - 10/14/19-positive Review on 10/23/19 client #11452 revea - "30 Day Follow Up 07/10/19. Urine Dru ShowsTHC+ (pos advised to f/u (follo) UDS" Interview on 10/23/ - She had received approximately 4 mo - She had not seen admission. C. Review on 10/22/ revealed: - 39 year old male Admission date of - Diagnosis of Opio - No counselor note address positive UI Review on 10/22/19 08/13/19 thru 09/13 - 08/13/19-positive - 09/13/19-positive Interview on 10/22/ stated: - She started at the	for Tetrahydrocannabinol for THC. for THC. for THC. for THC. 9 of an unsigned case note for alled: 9 - Date of Admission: On all Screens: On 07/31/19 stitive)Plan: Pt. (patient) w up) with the counselor for 19 client #11452 stated: services at the facility for boths. a counselor since her 2/19 of client #11332's record 6 05/24/19. id Use Disorder-Severe. es from 08/19 and 09/19 to DS's. 9 of client #11332's UDS from 8/19 revealed: for Fentanyl (opiate). Amphetamine and Fentanyl. 19 the Clinical Manager facility on 08/26/19.	V 233			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	PLE CONSTRUCTION (X3) DATE SUI COMPLET		
			B. WING		R	
		MHL096-186	B. WING	 -	10/2	3/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
CAROLIN	NA TREATMENT CEN	IFR OF GOLDSB	T ASH STRE DRO, NC 27	ET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 233	Continued From pa	ge 10	V 233			
	- She had been the the facility for a brie - The nursing staff see clients in the every - She had seen clien notified.	case manager for all clients at f period of time. should notify the counselor to vent of positive UDS's. nts for positive UDS's when				
	Director stated: - All the previous co - New counselors h	19 and 10/23/19 the Clinical bunselors had left the facility. ad been hired. The new rrently being assigned to the				
V 235	27G .3603 (A-C) Ou	utpt. Opiod Tx Staff	V 235			
	counselor or certifies to each 50 clients a on the staff of the fathis prescribed ratio individual who is ce unavailability of cert hiring area, then it reperson, provided the certification requires months from the da (b) Each facility shamember on duty tra (1) drug abus (2) symptoms to drug addiction. (c) Each direct care continuing education the following: (1) nature of (2) the withdress.	and certified drug abuse and substance abuse counselor and increment thereof shall be acility. If the facility falls below and is unable to employ an artified because of the acility's may employ an uncertified at this employee meets the ments within a maximum of 26 at e of employment. The following areas: we withdrawal symptoms; and as of secondary complications are staff member shall receive in to include understanding of				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	3
		MHL096-186	B. WING		10/2	3/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAROLI	CAROLINA TREATMENT CENTER OF GOLDSB GOLDSB			EET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 235	(4) infectious sexually transmitted This Rule is not me	diseases including HIV, d diseases and TB.	V 235			
	failed to ensure a mabuse counselor or counselor was on sincrements thereof. Review on 10/23/19 - A census of 215 a - 1 Licensed Clinica (LCSW)/Clinical Ma of 70 clients - 1 Licensed Clinica	ninimum of one certified drug certified substance abuse staff to each 50 clients or The findings are: Of facility records revealed: active clients. Al Social Worker anager on staff with a caseload al Addiction ed (LCAS-R) staff with a				
	stated: -She had just bega and had a caseload Interview on 10/22/stated: - She started at the - She had a current - All the previous co - She had hired new - She had been the facility for a brief Interview on 10/22/Director stated:	19 the Clinical Manager facility on 08/26/19. caseload of 65 clients. cunselors had left the facility. v counselors. case manager for all clients at				

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STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		R	
		MHL096-186	B. WING			3/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAROLI	NA TREATMENT CEN	LER OF GOLDSB	T ASH STRE ORO, NC 27	ET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 235	Continued From pa	ge 12	V 235			
		ad been hired. The new rrently being assigned to the				
		s been cited 3 times since the tember 21, 2017 and must be days.]				
V 238	27G .3604 (E-K) O	utpt. Opiod - Operations	V 238			
	238 27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program approval on the following criteria: (1) compliance with all state and federal law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		MHL096-186		B. WING			23/2019
NAME OF	PROVIDER OR SUPPLIER	STF	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
CAROLI	NA TREATMENT CEN	TER OF GOLDSB		RO, NC 27	EET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 238	Continued From pa	ge 13		V 238			
	(1) Levels of following conditions (A) Level 1. It continuous treatmel limited to a single of shall ingest all other the clinic; (B) Level 2. continuous program granted for a maximand shall ingest all at the clinic each w (C) Level 3. treatment and a micontinuous program client may be grant take-home doses a under supervision at (D) Level 4. A treatment and a micontinuous program client may be grant take-home doses a under supervision at (E) Level 5. treatment and a micontinuous program granted for a maximand shall ingest at supervision at the of (F) Level 6. treatment and a micontinuous program client may be grant take-home doses a dose under supervidays; and (G) Level 7.	Eligibility are subject to the current of the compliance, a client manum of 90 days of a compliance at level 2, and the current of a maximum of four and shall ingest all other compliance at level 2, and the current of a maximum of some of a compliance at level 2, and the clinic each week; after 270 days of a compliance at level 3, and the clinic each week; after 270 days of a compliance at level 3, and the clinic each week; after 364 days of continuous of the clinic each week; after 364 days of continuous of the clinic each week; after 364 days of continuous of the clinic each week; after 364 days of continuous of the clinic each week; after 364 days of continuous of six take-home do east one dose under	f y is client on at ays of ay be doses vision uous a ir doses uous ay be oses uous ay be oses uous a ir doses ay be oses uous ay be oses uous a ir doses ay be oses uous ay be oses uous a ir doses uous ay be oses uous a				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL096-186		B. WING			R 23/2019	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE		20/2010
CAROLI	NA TREATMENT CEN	LER OF GOLDSB	AST ASH STRI BORO, NC 27	EET, SUITE 200, 201, 202 & 30 530	0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 238	continuous program granted for a maxim and shall ingest at I supervision at the c (2) Criteria for Reinstatement of Ta (A) A client's tor suspended for exaction of eligibilit (B) A client who tests p within a 90-day perireduction of eligibilit (B) A client who screens within the sall take-home eligibility shall be do Opioid Treatment P (3) Exception (A) A client in continuous treatment he applicable mandexceptional circums personal or family compay be permitted aby the State authorifound to be response Except in instances verifiable physical cof 13 take-home doperiod during the first treatment. (B) A client who tests provide the same and the same eligibility disability may be grant at the same eligibility disability may be grant eligible eligi	n compliance, a client may be num of 30 take-home doses east one dose under linic every month. r Reducing, Losing and ake-Home Eligibility: ake-home eligibility is reduced idence of recent drug abused ositive on two drug screens od shall have an immediate try by one level of eligibility; ho tests positive on three drug ame 90-day period shall have an immediate try by one level of eligibility; ho tests positive on three drug ame 90-day period shall have and tatement of take-home etermined by each Outpatien	ed			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
MHL096-186		B. WING			3/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAROLI	NA TREATMENT CEN	TER OF GOLDSB	T ASH STRE DRO, NC 27	ET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 238	make monthly clinic (4) Take-Hom Take-home dosage medications approvaddiction shall be a physician on an indito the following: (A) An addition methadone or othe treatment of opioid to each eligible clie treatment) for each (B) No more methadone or othe treatment of opioid to any eligible clien restriction shall not receiving take-hom above. (g) Withdrawal From Opioid Treatment. Withdrawal from meapproved for use in discussed with each treatment and annum (h) Random Testin and other drugs shadtive opioid treatment. Addition three-month period treatment episode, will be observed by to include at least the methadone, cocain amphetamines, Thalcohol. Alcohol testing the provision of the same treatment.	c visits. ne Dosages For Holidays: es of methadone or other yed for the treatment of opioid authorized by the facility dividual client basis according anal one-day supply of r medications approved for the addiction may be dispensed nt (regardless of time in state holiday. than a three-day supply of r medications approved for the addiction may be dispensed to because of holidays. This apply to clients who are e medications at Level 4 or and Medications For Use In The risks and benefits of ethadone or other medications a opioid treatment shall be h client at the initiation of ally thereafter. g. Random testing for alcohol all be conducted on each ment client with a minimum of est each month of continuous hally, in two out of each of a client's continuous at least one random drug test a program staff. Drug testing is the following: opioids, e, barbiturates, C, benzodiazepines and sting results can be gathered breathalyzer or other	V 238			

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DIVISION	of Fleatill Service IN	Squiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPI	LETED
					_	
			D WING		R	
		MHL096-186	B. WING		10/2	3/2019
NAME OF I	PROVIDER OR SUPPLIER	STDEE	ADDRESS, CITY,	STATE ZID CODE		
IVAIVIL OF I	NOVIDEN ON OUT LIEN					
CAROLII	CAROLINA IREALMENT CENTER OF GOLDSB			EET, SUITE 200, 201, 202 & 300		
		GOLD	SBORO, NC 27	7530		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IGIENOT)		
V 238	Continued From pa	ige 16	V 238			
	•					
		Restrictions. No client sha	I			
	be discharged from	the facility while physically				
	dependent upon me	ethadone or other medication	ns			
	approved for use in	opioid treatment unless the				
		e opportunity to detoxify from				
	the drug.	,				
		Prevention. All licensed				
		diction treatment facilities				
	which dispense Me					
		Methadol (LAAM) or any oth	or			
		gent approved by the Food a	iiu			
		for the treatment of opioid				
		ent to November 1, 1998, are				
		ate in a computerized Centra	al			
		that clients are not dually				
		of direct contact or a list				
		pioid treatment programs				
		mile radius of the admitting				
	program. Programs	s are also required to				1
	participate in a com	nputerized Capacity				
	Management and V	Vaiting List Management				
	System as establish	hed by the North Carolina				
	State Authority for 0	Opioid Treatment.				
		rol Plan. Outpatient Addiction	n l			
		Programs in North Carolina a				
	•	h and maintain a diversion				
		of program operations and				
		plan in their policies and				
		rsion control plan shall inclu	de			
	the following eleme		ue			
	(1) dual enrollment prevention measures that consist of client consents, and either					<u> </u>
		participation in the central				
	registry or list excha]
		or bottle checks, bottle return	is			
	or solid dosage forr					
	` ,	or drug testing;				
		ng results that include a]
	review of the levels of methadone or other					Ì

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL096-186		B. WING			R 23/2019	
	PROVIDER OR SUPPLIER	TER OF GOLDSB 1700 EAS		STATE, ZIP CODE SET, SUITE 200, 201, 202 & 300 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 238	medications approvaddiction; (5) client atte	red for the treatment of opioid and ance minimums; and ses to ensure that clients	V 238			
	interviews, the facili implemented policie home dosages affe (#11247 and #1145. A. Review on 10/23 revealed: - 43 year old female - Admission date of	eview, observations and ty failed to ensure staff es and procedures on take cting 2 of 15 current clients 2). The findings are: /19 of client #11247's record				
	orders and Urine Di 08/13/19 - Client #11247 was to 145 milligrams(m amphetamine (stim - Client #11247 had discontinued.	take home Methadone doses				
	resume 4 take hom Review on 10/23/19 Medical Record for	s approved by the physician to e doses of Methadone. of client #11247's Patient September 2019 revealed the a take home dose was ohysician order and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL096-186		B. WING			R 23/2019
	CAROLINA TREATMENT CENTER OF GOLDSB				ETATE, ZIP CODE EET, SUITE 200, 201, 202 & 3 530	300	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 238	- She had received more than one year - She did not have a - She had attended facility She currently had B. Review on 10/23 revealed: - 26 year old female - Admission date of - Diagnosis of Opio Review on 10/23/19 results revealed: - 07/22/19-positive (THC) 07/31/19-positive - 09/09/19-positive - 10/14/19-positive -	compliance: 19 client #11247 stat services at the facility. a current counselor. some group meeting four take home dose in the facility of client #11452's e. 107/10/19. 10 Use Disorder-Sever of client #11452's Uffor Tetrahydrocannal for THC. 10 for THC. 10 for THC. 10 of client #11452's Par September 2019 an alled the following day was provided without	ey for gs at the es. s record ere. UDS binol	V 238			
	- She had received months.	services for approximation	mately 4				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED	
MHL096-186			B. WING			R 23/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	1011	LO/2010
CAROLI	NA TREATMENT CEN	TER OF GOLDSB	T ASH STRE	EET, SUITE 200, 201, 202 & 30 '530	0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 238	- She did not have due to positive UDS - She was aware of home doses. Interview on 10/23/ stated: - Clients that test poshould not have tak - The computer proclients to receive ta	current take home dosages S. I the criteria for receiving take 19 the Clinical Manager Distive for illicit substances the home doses. I gram had allowed for some ke homes for Sunday. Distincted the software company	V 238			