STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on November 15, 2019. The complaints were unsubstantiated (intake #NC00155219 and # NC00156664). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.	V 000		
V 280	27G .4501 Sub. Abuse Comp. Outpt. Tx.- Scope 10A NCAC 27G .4501 Scope (a) A substance abuse comprehensive outpatient treatment program (SACOT) is one that provides a multi-faceted approach to treatment in an outpatient setting for adults with a primary substance-related diagnosis who require structure and support to achieve and sustain recovery. (b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse, and other homogenous groups. (c) SACOT shall have a structured program, which includes the following services: (1) individual counseling; (2) group counseling; (3) family counseling; (4) strategies for relapse prevention to include community and social support systems in treatment; (5) life skills; (6) crisis contingency planning; (7) disease management; (8) service coordination activities; and	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 1 (9) biochemical assays to identify recent drug use (e.g. urine drug screens). (d) The treatment activities specified in Paragraph (c) of this Rule shall emphasize the following: (1) reduction in use and abuse of substances or continued abstinence; (2) the understanding of addictive disease; (3) development of social support network and necessary lifestyle changes; (4) educational skills; (5) vocational skills leading to work activity by reducing substance abuse as a barrier to employment; (6) social and interpersonal skills; (7) improved family functioning; (8) the negative consequences of substance abuse; and (9) continued commitment to recovery and maintenance program. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure it operated within the scope of a comprehensive outpatient treatment (SACOT) program. The findings are: Review on 10/15/19 of the facility's written SACOT program description dated 10/5/18 revealed: -The program description was 21 pages in length; -There was no written language that indicated the SACOT program was or was to be referred to as a partial hospitalization program (PHP). Reviews from 10/10/19-10/18/19 of Clients #4,#5, #6, #7,#8, #9 and Deceased Client (DC #10)'s records revealed: -The word or term "PHP" in the client treatment	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 2	V 280		

plans and written daily and weekly progress notes was repeatedly used in lieu of the word "SACOT" or "substance abuse comprehensive outpatient treatment."

Interview on 10/9/19 with Client #4 revealed:
-He was admitted to "PHP" 26 days ago, which was a daily intensive substance abuse group treatment program ran by the facility;
-PHP stood for "partial hospitalization program;"
-He was not familiar with the word(s) SACOT or substance abuse comprehensive outpatient treatment program;
-His description of the PHP's program operation of 5 days a week, Monday-Friday from 9:00 am to 3:30 pm with group and individual counseling, relapse prevention strategies that included community and social support were consistent with the SACOT program criteria;
-On 10/11/19, he planned to move from PHP to an "IOP" or substance abuse intensive outpatient treatment program (SAIOP), which was a less intensive group treatment of 3 days a week but continued with individual counseling and community supports.

Interview on 10/9/19 with Client #5 revealed:
-He verbalized the word "PHP" when he described his attendance and participation in the SACOT program.

Interview on 10/17/19 with Client #6 revealed:
-She was admitted to the "PHP" on 10/5/19, which stood for partial hospitalization program;
-Her description of the PHP was about 3-4 morning group treatment groups ran for about an hour each with a break in between, a 1-hour lunch, and followed by afternoon treatment groupwork ran for 1-1 ½ hours until 3:30-4:00 pm;
-She stated the PHP group treatment was held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 3 separately from the substance abuse intensive outpatient treatment (IOP) groups; -She could not recall if staff used another word for PHP. Interview on 10/9/19 with the Clinical Director/Vice-President (VP) revealed: -PHP meant "partial hospitalization program," which was the SACOT program operated by the facility; -She believed the word "PHP" was used for insurance billing purposes. Interview on 10/11/19 with the Chief Executive Officer (CEO) revealed: -PHP stood for partial hospitalization program which was the terminology his company used in other states such as Arizona and was used instead of SACOT for billing purposes; -He understood the local facility was licensed for the SACOT and SAIOP programs and was not licensed for PHP; -He acknowledged the facility staff needed to refer to the program as SACOT and not PHP in their verbal and written client communications which included client treatment plans. Review on 10/10/19 of the facility's program brochure revealed the facility's program services included 24/7 supervised residential options. Review on 10/17/19 of an internet search for the facility revealed: -The facility's website quoted statements which included, "We offer supervised residential living options for those in our outpatient program" and "Our women's and men's houses ... with comfortable amenities and a compassionate team of around-the-clock supervisors."	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 4 Review on 10/9/19 of a facility employee list revealed: -The first section had a total of 18 current employees with their individual positions/titles, credentials (as applicable), and their dates of hire; -1 employee was in a position of Residential Coordinator with a hire date of 4/14/19; -5 of the 18 employees were in technician positions; -The Licensee/CEO's information was absent from this staff list; -The Clinical Director, who had a hire date of 12/1/18, was credentialed as an LCAS (Licensed Clinical Addiction Specialist), a CCS (Certified Clinical Supervisor) and she was identified as a Vice President (VP) of Operations; -The 2nd staff section had 4 subcontracted employees with their individual positions/titles, credentials (as applicable), and their dates of hire; -The 3rd and last section contained a list of terminated employees with their former positions/titles, credentials (as applicable), date of hires and dates of termination. Review on 10/9/19 of a Level III handwritten death report on DC #10 on a Department of Health and Human Services (DHHS) form revealed: -On page 3 of 4 of the report and in the "provider information" section, the facility director of the care community home where DC #10's death occurred had the name of the facility's Chief Executive Officer (CEO). Review on 10/18/19 of an undated, written client request form at the SACOT and SAIOP outpatient treatment facility and interview on 10/18/19 with	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 5	V 280		

the Corporate Compliance Officer (CCO) about this written request revealed:
-Client #11 made a request for her family to visit her sober living home on 10/20/19, which was on Sunday;
-Client #11 lived in the women's SACOT/SAIOP home and was a client in the outpatient SACOT program;
-She made her request on the form while at the outpatient program for her therapist or the Clinical Director/VP to approve of the visit and whether they could bring her car to her at the sober living home when they visited;
-The Clinical Director/VP approved Client #11's request.

Review on 10/10/19 of Client #3's record revealed:
-Date of admission: 9/5/19;
-His initial clinical intake assessment, which was dated and signed on 9/6/19 by the Clinical Director, included:
-his diagnoses of Alcohol Use Disorder-Moderate, Cocaine Use Disorder-Moderate, Major Depressive Disorder, Recurrent-Mild;
-a statement that, "It is imperative at this time that ct (client) receive residential level of care that can provide a structured and controlled environment while ct is developing increased levels of biopsychosocial health and initiating positive lifestyle changes free of alcohol and drug use in addition to stabilizing untreated and/or underlying mental health concerns;"
-a written treatment order which stated, "Due to the lethal nature of choice of alcohol, ct will initiate comprehensive treatment interventions at residential level of care x 7 days/week ...;"
-His 9/5/19 written and signed admission paperwork included a signed consent for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 6	V 280		

treatment, and the licensee's program rules and regulations, personal and client rights, financial responsibility policies, and written liability waivers for transportation service;
-A residential coordinator who was named as a facility staff signed Client #3's 9/5/19 admission paperwork.

Interview on 10/9/19 with Client #3 revealed:
-He was admitted to the facility's PHP(partial hospitalization program)/SACOT program on 9/5/19 for treatment of his addiction to alcohol and cocaine;
-PHP had the same meaning to Client #3 as SACOT;
-He was in the SACOT program for 30 days and "graduated" to SAIOP on 10/4/19;
-He stayed at the SACOT house while he was in the SACOT program because this living arrangement was expected of him while he received SACOT treatment in the outpatient facility;
-Clients in SAIOP had various living arrangements such as the SAIOP house, their own home, with family, or in a half-way house;
-There were "techs" (technicians) at both the SACOT and SAIOP houses;
-These staff monitored their (clients') behaviors in the houses and provided them with transportation to and from the outpatient treatment program and activities in the community;
-The technicians worked at the outpatient facility as staff and one of their job duties was to observe client urine drug screens based on client gender;
-When DC #10 died at the SACOT house on 9/30/19, facility staff moved him and his peers from the SACOT house to an "Airbnb" (rental house) for one week for the house where DC #10's death occurred to be thoroughly cleaned;
-SAIOP clients moved into the SACOT house

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 7 while he and his peers moved into another house to not have the memories of DC #10's death. Review on 10/10/19 of Client #4's record revealed: -Date of admission: 9/12/19; -His initial clinical intake assessment, which was dated and signed on 9/12/19 by the Clinical Director, included: -his diagnoses of Opioid Use Disorder-Severe, Sedative, Hypnotic or Anxiolytic Use Disorder-Severe, Alcohol Use Disorder-Severe; -a recommended treatment plan for SACOT day treatment 5 days a week to provide a structured and controlled environment during the initial phase of treatment; -his services were to include a sober living environment, 12-step program, and referrals to the facility's medical and psychiatric physicians to evaluate physical health and co-occurring mental health diagnoses. Interviews on 10/9/19 and 10/11/19 with Client #4 revealed: -10/9/19, he was admitted on 9/12/19 to the SACOT program for his alcohol and cocaine addiction after he was discharged from a local alcohol and drug detoxification center; -10/11/19, he was "required to live in the PHP (SACOT) house to attend the PHP (SACOT) program;" -He did not recall who told him about the requirement, but he knew this information at his admission; - Client #4's description of PHP matched the facility's SACOT's program description; -He planned to move from the SACOT house at 12:30 pm on this date, 10/11/19, to the SAIOP house because he was moving to the SAIOP program and he wanted to live in the SAIOP	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 8	V 280		

house;
-There were 3 local houses run by the facility's SACOT and SAIOP owner which included a men's SACOT house, a men's SAIOP house and a combined women's SACOT/SAIOP house;
-The SACOT house was staffed by at least one technician who was present at the house whenever a client was present because the facility's rationale was the SACOT clients had addictions and behavior issues that needed to be monitored "24/7;"
-The technicians had additional certifications or license that related to alcohol and drug addictions and they worked at the house on rotating shifts to provide the clients with transportation to the grocery store, pharmacy, Alcoholic Anonymous (AA)/Narcotics Anonymous (NA) meetings in the community, and to the facility during the weekdays to the SACOT program;
-There were written house rules posted in the SACOT house which included scheduled times of the mornings and of the evenings for self-administration of medications;
-Client medications were locked up to keep the medications from being stolen;
-Clients were not allowed to leave the house unless they were provided with a "pass" (written approval by a facility's clinical staff member to go out into the community, even to an AA/NA meeting), and there was no use of personal cell phone or electronics for the first 2 weeks of admission;
-Non-compliance with a visit pass into the community such as returning later than expected to the SACOT house could result in having privileges such as a cell phone removed but staff gave verbal warnings before they removed a privilege;
-He made a written financial agreement with SACOT house to pay $1500 for the first 30 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 9	V 280		

of his stay at the SACOT house;
-He was to pay $1500 when he moved into the SAIOP house.

Review on 10/10/19 of Client #5's record revealed:
-Date of admission: 9/20/19;
-His initial clinical intake assessment, which was dated and signed on 9/20/19 by the Clinical Director, included:
-his diagnoses of Opioid Use Disorder-Severe and Cannabis Use Disorder-Severe;
-a recommended treatment plan for SACOT services 5 times per week for substance abuse treatment.

Interview on 10/11/19 with Client #5 revealed:
-He was admitted to the SACOT program on 9/20/19 from a local alcohol and drug detoxification center after he talked with a facility's Outreach staff by telephone call and after he was declined admission to another treatment program;
-The facility's Outreach staff told him:
-about outing opportunities during his treatment period to go hiking and to the gym;
-after the 1st two weeks of admission, his cell phone and gaming system would be returned to him, but he had to remain focused on his recovery plan to keep these items in his possession;
-his housing was included in his treatment and recovery plan;
-the housing, which was a "sober living house," was located off the grounds from the SACOT facility and he was to be monitored 24 hours a day by staff at the house;
-During his first 2 weeks at the SACOT house, he did not have his cell phone or gaming system, but he was allowed, during that time, to use the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 10	V 280		

facility's landline to make calls;
-He confirmed the SACOT house technicians also worked at the program facility during the weekday and performed different jobs that included cleaning the building, transportation and observing client urine drug screens (UDSs);
-He verified that clients who lived in the SACOT house were the same clients who attended the SACOT program at the outpatient facility he attended;
-He repeated the same information as Client #4 about the SACOT house rules about medication storage and medication self-administration time windows as well as the clients not being allowed to leave the house without an approved written pass by the facility's clinical staff.

Review on 10/18/19 of Client #6's record revealed:
-Date of admission: 10/4/19;
-His initial clinical intake assessment, which was dated and completed on 10/4/19 by the CSAC-I/IOP Counselor, included:
-his diagnoses of Substance Abuse Disorder-Severe, Other Stimulant Dependence-Uncomplicated; Alcohol Use Disorder-Moderate, and Major Depressive Disorder, single episode-moderate;
-a recommended treatment plan, which was signed by the Clinical Director, had he needed a "residential level of care that can provide a structured and controlled environment while ct (client) is developing increased levels of biopsychosocial health and initiating positive lifestyle changes free of alcohol and drug use in addition to stabilizing untreated and/or underlying mental health concerns;"
-services were to include a sober living environment, 12-step program, and referrals to the facility's medical and psychiatric physicians to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 11	V 280		

evaluate co-occurring mental health diagnoses.

Interview on 10/11/19 with Client #6 revealed:
-He was admitted on 10/4/19 when a family member brought him to the facility for treatment of his alcohol addiction;
-At admission, he went to live in the SACOT house as the first stage in his treatment;
-He was not aware he had a choice to live elsewhere during his SACOT outpatient treatment;
-At the SACOT house, which he believed was owned or operated by the Chief Executive Officer of the SACOT outpatient facility, there were rules, but he did not feel "imprisoned" or "stuck in a box;"
-The only issue he had with living in the SACOT house was "lights out at 11:00 pm" because he was not ready to go to sleep at that time and could not have his electronics on at 11:00 pm;
-Client #6 confirmed the house rules that were included in the interviews with Clients #4 and #5.

Review on 10/18/19 of Client #7's record revealed:
-Date of admission: 9/17/19;
-His initial clinical intake assessment, which was dated and signed on 9/17/19 by the Clinical Director, included:
-his diagnoses of Opioid Use Disorder-Severe, Sedative, Hypnotic or Anxiolytic Use Disorder-Severe, Alcohol Use Disorder-Severe; Obsessive-Compulsive Disorder (OCD), Generalized Anxiety Disorder (GAD), Major Depressive Disorder, recurrent-moderate;
-the same wording used in his assessment as was in Client #3's assessment which had, "It is imperative at this time that ct receive residential level of care that can provide a structured and controlled environment while ct is developing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 12	V 280		

increased levels of biopsychosocial health and initiating positive lifestyle changes free of alcohol and drug use in addition to stabilizing untreated and/or underlying mental health concerns;"
-his services were to include SACOT level of care 5 times a week, referral and evaluation by the facility's medical and psychiatric physician for physical and co-occurring diagnoses, attend Alcoholic Anonymous (AA)/Narcotics Anonymous (NA) meetings.

Interview on 10/17/19 with Client #7 revealed:
-He was admitted 9/18/19 for treatment of his addictions to alcohol and prescribed pain pills;
-He came directly to the facility from a local alcohol and drug detoxification center;
-Prior to the detox center, he had lived in a local apartment;
-This was his 4th time in substance abuse treatment and his 1st time in this facility's SACOT program;
-Since his admission, he lived in the PHP (SACOT) house which was a part of his treatment program;
-He guessed that was a part of the PHP (SACOT) program, which meant partial hospitalization program because clients could not have their own cars, there was constant house staff supervision, client medications were "controlled" (stored and made available at certain times of the day and evenings for clients to self-administer), and transportation was provided by the facility's van to and from the treatment facility;
-His last day at the SACOT house was tomorrow, 10/18/19;
-He was transitioning over to SAIOP on 10/18/19 and planned to return to live in his own home;
-He had not paid attention to other housing options at the time of his admission;
-He believed the SACOT house was a "good

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 13	V 280		

place to stay" when he signed a contract with the facility which included a housing cost of around $1500.00 for 1 month;
-At his SACOT admission, he needed to be removed from people who used alcohol and drugs for at least the first 30 days to help him in his sobriety;
-He liked the treatment program provided by the facility because he did not feel "shamed" because of his addiction.

Review on 10/18/19 of Client #8's record revealed:
Date of admission: 10/6/19;
-Her initial clinical intake assessment, which was dated and signed on 10/7/19 by the Clinical Director, included:
-her diagnoses of Major Depressive Disorder, recurrent-Moderate, Post-Traumatic Stress Disorder (PTSD) unspecified, Cannabis Use Disorder-Moderate, Alcohol Use-Severe;
-her recommended services were daytime SACOT, a sober living environment, 12-step program, and referrals to the facility's medical and psychiatric physicians to evaluate physical health and co-occurring mental health diagnoses.

Interview on 10/17/19 with Client #8 revealed:
-She was admitted on 10/6/19 to the SACOT program for treatment of her alcohol addiction;
-Prior to her admission, she lived in a local apartment;
-She lived in the women's combined SACOT and SAIOP house;
-There were 8 women who lived in this house, but the house was considered at full capacity with 10 women;
-"If you are a PHP (SACOT) client, you have to live at the PHP (SACOT) house;"
-She did not recall what staff told her this;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 14 -She was aware that clients in the SAIOP outpatient facility lived where they chose; -Her family paid for her stay at the SACOT/SAIOP house; -There were 2 female technicians who rotated staff at the house when clients were present in the mornings, in the evenings, at night and on the weekends; -One of the female outpatient facility staff filled in as a technician at the house when needed; -The SACOT and SAIOP house clients were assisted by the technicians with activities that included observations of medication self-administration, transportation to medical specialists in the community and to grocery shop with their weekly $75 local grocery store gift card to purchase foods to prepare their individual meals; -There were written house rules and the rules she named were the same as Clients #4 and #5 named such as the cell phone use restriction during the first 2 weeks of admission, medication storage, and the SACOT clients not being allowed to leave the house without a written "pass" by a clinical staff which is obtained at the facility. Interview on 10/17/19 with the Residential Coordinator revealed: -He was considered facility staff at the outpatient treatment facility and community care houses; -His job duties included: -training, supervising, and scheduling the work of 8 behavioral technicians at the facility and at the SACOT and SAIOP community care houses; -making minor repairs at these houses such as plumbing problems or patching wall holes; -running errands during the day while clients were at the outpatient treatment facility which included picking up client grocery store gift cards for the technicians to take clients who lived in the	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 15 SACOT and SAIOP houses to grocery shop on the weekends for their weekly meals and personal care items; -The job duties of the technicians at the facility during their daytime work schedule (9:00 am-12:00 noon for SAIOP and 3:30/4:00 pm for SACOT) included: -cleaning the outpatient facility, observing client UDSs according to client gender, and providing client transportation to appointments, meetings and to volunteer opportunities in the community; -The job duties of the technicians in the SACOT/SAIOP houses included: -ensuring client prescribed medications were locked up (secured) except when each client was scheduled to take their medication; -observing clients self-administer their medications; -providing transportation to the grocery store, pharmacy, AA/NA meetings, to the local gym, and on various weekend outings that included hiking and water rafting trips; -The SACOT clients who lived in the SACOT houses attended the same SACOT outpatient treatment facility; -The SACOT clients did not live in other housing arrangements; -"They are required to come here." -SACOT clients completed a "Care Community Housing Intake" packet at the time of their admission to the SACOT houses for "liability purposes;" -He or one of the behavior technicians went over the housing form packet with each SACOT client and signed off as a witness to their (the client's) signature on each form; -There was a written policy that the SACOT clients cannot be approved to have passes to leave the house for or to receive family visits the first 2 weeks;	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 16 -No one approved a SACOT client's pass request except for the facility's Clinical Director/VP; -The SACOT client made their written request while at the facility's outpatient program and after the Clinical Director/VP made her decision, the pass request was returned to the client by one of the technicians. Interviews on 10/10/19, 10/15/19, and 11/15/19 with the CEO revealed: -10/10/19, the clients in the SACOT and SAIOP programs had a choice where they lived; -The outpatient facility was a separate, licensed entity from the local "sober living houses," which were unlicensed community care homes where some of the clients lived who attended the outpatient facility; -10/15/19, he identified a separate company (non-profit company) as owner for the local "sober living" houses where the clients of the SACOT program lived; -He stated the SACOT clients were not required to live in the SACOT houses; -The clients could live in other sober living houses if the owners/managers of the houses were willing to work with him to ensure the clients were safe and remained sober; -4 local sober living homes the facility worked with; -He had past experiences with other local sober living homes where clients came to the outpatient treatment facility high from illicit substances or were intoxicated which was not safe for these individuals or safe for the clients at the treatment program who were working on their sobriety; -If a SACOT client chose to live with their family, he was willing to meet with the family members to ensure all family members understood they had to be an active participant in monitoring and supervising of the client's sobriety	V 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 280	Continued From page 17 and getting the client to the program on time for treatment; -The keys to treatment and recovery were "safe and stable;" -Clients who stayed in the SACOT/SAIOP houses paid $1500 per month which included a variety of costs: food (clients purchased and prepared their own meals), group activities that included dinners out in the community, movies, white-water rafting, transportation costs to 12-step programs in the area, and gym memberships; -There were times a client's inability to pay the housing cost did not prevent their being admitted to the community care house or outpatient treatment program; -There were no client treatment plans as part of their housing but there were guidelines clients were expected to follow such as a house manager was present at a house whenever a client was present to monitor for safety purposes; -11/15/19, he accepted 2 SACOT client admissions this month (11/2019) whose living arrangements were somewhere else other than the SACOT houses; -1 of the 2 clients wanted to live in another sober living home; -Both clients came to their screening and intake appointments with individual and specific action plans about how they planned to stay safe and sober with their use of the SACOT outpatient day treatment to stay safe and sober and both clients were admitted; -He acknowledged he understood a client's right to choose their living environment during substance abuse outpatient treatment.	V 280		
V 367	27G .0604 Incident Reporting Requirements	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 367	Continued From page 18 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit,	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 367	Continued From page 19 upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 367	Continued From page 20 through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all Level III incidents of clients who received services within 90 days of service delivery to MH/DD/SA and the Local Management Entity (LME) responsible for the service area where the services were provided. The findings are: Review on 10/9/19 of written facility incident reports for the period 8/1/19 to 10/9/19 revealed: -4 facility incident reports were reviewed; -3 of the 4 reports were Level I incidents; -1 of the 4 reports was an internal Level III incident, which was dated 9/30/19 with a time of 7:00 am and gave a description of Deceased Client (DC #10) having died from a suspected drug overdose in the bathroom of a community care home where he lived; -Local medical emergency service responded to a 9-1-1 call from the home and related to DC #10; -Local law enforcement initiated an investigation of DC #10's death at the home; -The facility's Chief Executive Officer (CEO) and the Clinical Director/Vice President (VP) had follow up involvement related to DC #10's death; -The report was completed on 10/7/19 by the facility's Residential Coordinator. Review on 10/9/19 of a Level III handwritten death report on DC #10 on a Department of Health and Human Services (DHHS) form revealed: -While his substance abuse and mental health diagnoses were listed on the report, there was no	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 367	Continued From page 21	V 367		

information about his substance abuse treatment services that he received from the facility;
-The form, dated 9/30/19, was signed by the facility's Residential Coordinator and Corporate Compliance Officer;
-Written instructions were on the form to send or fax the report to the DHHS Complaint Intake Unit (CIU);
-There was no documentation that the handwritten form was mailed or faxed to CIU on DC #10.

Review on 10/10/19 of DC #10's record revealed:
-Admission date: 9/10/19;
-Date of death: 9/30/19;
-Diagnoses: Opioid Use Disorder-Severe, Obsessive-Compulsive Disorder (OCD), and Major Depressive Disorder-recurrent episode, severe;
-He had an active treatment record at the facility from the date of his admission which included:
  -a 9/9/19 pre-admission screening;
  -a 9/10/19 intake assessment and a written treatment plan;
  -a 9/11/19 assessment of his mental health diagnoses by the facility's mental health provider with medications prescribed for his OCD and Depression;
  -daily written progress notes which indicated his participation in the substance abuse comprehensive outpatient treatment (SACOT) program;
  -results of his random urine drug screens (UDS) from 9/10/19 to 9/23/19 were negative for illicit substance use;
  -his last UDS report was dated 10/1/19, which was after his death, was positive for an illicit substance.

Review on 10/10/19 of the facility's written policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-423	A. BUILDING: _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS RECOVERY TREATMENT CENTER	191 CHARLOTTE STREET, #200 ASHEVILLE, NC 28801

(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 367	Continued From page 22 on incident reporting dated 10/5/18 revealed the facility was to send a copy of all Level III incident reports to MH/DD/SA and the LME within 72 hours for clients who had received services within a 90-day period. Interview on 10/9/19 with the Clinical Director/ Vice-President (VP) of Operations revealed: -Her hire date was 12/1/18; -She supervised the overall clinical staff in the SACOT and substance abuse intensive outpatient (SAIOP) programs; -She had past work experience in completing and submitting IRIS reports; -The Corporate Compliance Officer was responsible for completing and submitting the IRIS reports. Interview on 10/9/19 with the Corporate Compliance Officer/ CSAC-I revealed: -His hire date was 1/2/19; -He was uncertain what State agency to submit the death report on DC #10; -DC #10's death occurred in an unlicensed community care home; -DC #10 had received substance abuse treatment services from the outpatient facility within 90 days of his death; -He had not had the IRIS training to complete and submit Level II and III reports, but he was willing to go online for the training today, 10/9/19, to complete this training and to complete an IRIS report for DC #10; -The facility had been licensed in 12/2018 and had not had any Level II or III incidents until DC #10's death.	V 367		