STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **MHL049-147** **Intake # NC00158489**	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED **12/23/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAPHA HEALTHCARE SERVICES-MOORESVILLE	**207 SOUTH BROAD STREET, MOORESVILLE, NC 28115**

(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 ORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) **Corrective Action**	Person Responsible	(X5) COMPLETE DATE (Time Line)
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 12/23/19. The complaint was substantiated (intake #NC00158489). 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. Element 27G .0202 (A-E) Personnel Requirements Standard	V 000	RAPHA Corporate compliance will Review Results of Audit and send Plan of Correction to the Division of Health Regulations Corporate Compliance and HR will Review **http://www.ncdhhs.gov/dhsr/mhlcs/training.html** and register relevant staff for sessions	Managing Member Corporate Compliance HR Manager	Completed by 15th January 2020 Completed by 1st February 2020
V 107	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification **Deficiency / Finding** This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 1 former Licensed Clinical Addiction Specialist (LCAS) personnel record included a job description. The findings are: Review on 12/20/19 of the former LCAS personnel record revealed: -A hire date of 1/22/19; -No documentation of a job description was available. Interview on 12/23/19 with the Licensee revealed: -The former LCAS informed her on 12/11/19 that she was resigning from her position immediately; **(f)**-The former LCAS was a contract worker and provided individual therapy; **(g)**-She wasn't aware that she needed to have a job description for the former LCAS	V 107	HR Manager Will Review 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS HR Manager will sign Documentation attesting that the HR Manager has read and understood Personal Requirements HR Manager will use the Standard Auditing Tool and Review and Audit all HR Charts and will show results of audit to Managing Member HR Manager will create job descriptions for all staff with the appropriate elements included in each job description and have each job description signed by each staff and placed in their HR charts	HR Manager Managing Member Corporate Compliance	Completed by 25th January 2020 Completed by 8st February 2020 Completed by 15th February

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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V 111	**Element** 27G .0205 (A-B) Assessment/Treatment/Habilitation Plan **Standard** 10A NCAC 27G .0205ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1)the client's presenting problem; (2)the client's needs and strengths; (3)a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4)a pertinent social, family, and medical history; and (5)evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (c)(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. (d) **Deficiency/ Finding** This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an assessment was completed for clients prior to the delivery of services effecting 1 of 3 clients (client #3). The findings are: Review on 12/20/19 of client #3'srecord revealed: -No documentation of a date of admission was available; -No documentation of diagnosis was available; -No assessment documentation was available; -A service authorization from the Local Management Entity date of 12/2/19; -Notes dated 12/6/19, 12/9/19, 12/11/19, 12/13/19 and 12/16/19 that indicated the client had attended substance abuse intensive outpatient program (SAIOP) group meetings; -No documentation of drug screening results were available. Interview on 12/20/19 with client #3 revealed: -He had attended SAIOP group meetings 3 times a week during the month of December 2019; -He was referred to the program by the dialysis center; -He was attempting to get on the liver transplant list but was informed that wasn't possible until he received substance abuse treatment; -He had no current substance abuse issues; -He quit smoking marijuana in October 2019 and quit drinking alcohol on 1/21/19; -He had been administered his first drug screening today (12/20/19) by the Licensee. Interview on 12/19/19 with the Licensee revealed: -It was the former Licensed Clinical Addiction Specialist (LCAS) responsibility to complete assessments, treatment plans and provide individual therapy; -There was confusion for a couple of weeks in the beginning of of December about whether the former LCAS was going to return to work and what she had completed when she had worked; -The former LCAS had informed her on 12/11/19 that she wasn't going to return to work; -The Office Manager discovered the week that the former LCAS resigned that client #3's assessment had not been completed; -The Licensee had visited the facility on 12/13/19 to begin the assessment for client #3 but had not completed it; -The Licensee was going to be responsible for completing assessments until another LCAS was hired; -"I needed to synchronize everything."	V 111	Staff have been put in place to ensure that all Comprehensive Clinical Assessments are being completed, signed and done to reflect accurate service recommendations. Newly Hired Staff have a 48 hr submission time frame of required documentations The CCA's and Treatment Plan's and Crisis plans are to be signed by patient and clinician before the document is placed in patient's chart Enforcement of the use of Checklist form in Clients charts. All staff providing Services are required to check to ensure that client has had CCA and treatment plans and meet criteria for services to be provided. The check list will be signed by staff providing Services to ensure that the client meets all requirements to begin service. The checklist will be reviewed Supervisor and Manager and forwarded to Compliance Office and Managing member	Managing Member Corporate compliance Clinical Director Licensed Clinician	Completed by 7th February

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V 112	**Element** 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan **Standard** 10A NCAC 27G .0205ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c)The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d)The plan shall include: (1)client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2)strategies; (3)staff responsible; (4)(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5)(5) basis for evaluation or assessment of outcome achievement; and (6)written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. **Deficiency/ Finding** This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to implement treatment plans for 1 of 3 current clients (client #2) and 1 of 1 former client (FC #4). The findings are: Review on 12/19/19 of client #2's record revealed: -No documentation of an admission date; -An authorization for Substance Abuse Intensive Outpatient Program (SAIOP) services date of 12/4/19 from the Local Management Entity; -Diagnoses of Opioid Use Disorder, Major Depressive Disorder and Anxiety Disorder; -An assessment completed 8/29/19 included, "clinician (former Licensed Clinical Addiction Specialist (LCAS)) recommends that client (#2) participate in individual therapy 1-2 times per week and SAIOP 3 hours per day 3 times per week;" -A treatment plan dated 8/29/19 included, "will adhere to the requirements of medication assisted treatment to include participation in random drug screenings, abstinence from the use of opioids, and attending individual/group therapy session;" -Client #2 received individual therapy on 10/9/19, 10/16/19, 10/30/19, and 11/13/19. Attempts to interview client #2 on 12/19/19, 12/20/19 and 12/23/19 were not successful because the client failed to return telephone calls and attend group therapy at the facility. Review on 12/20/19 of FC #4's record revealed: -An admission date of 10/29/19; -Diagnoses of Opioid Use Disorder, Alcohol Use Disorder, Cocaine Use Disorder, Nicotine Use Disorder, Benzodiazepine Use Disorder, Crystal Methamphetamine Use Disorder, Major Depression, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder and Hypertension; -An assessment dated 10/29/19 included, "clinician (the Licensee) recommends that client (FC #4) participate in individual therapy 1-2 times per week and SAIOP 3 hours per day 3 times per week;" -A treatment plan dated 10/29/19 included, "will adhere to the requirements of medication assisted treatment to include participation in random drug screenings, abstinence from the use of opioids, and attending individual/group therapy sessions;" -There was no documentation that indicated FC #4 had received individual therapy. Attempts to interview FC #4 on 12/20/19 and 12/23/19 were not successful because the client failed to return telephone calls. Interview on 12/20/19 with the Licensee revealed: -She was aware that clients had not received individual therapy as indicated on their treatment plans; -She was in the process of looking for a new therapist to provide individual therapy.	V 112	Co-operate compliance will review all patients records for Assessments, Diagnosis, Treatment plans, and Crisis plans and ensure that all documents are up to date. Co-operate compliance will ensure that the checklist is signed in charts before staff begins services More protocols will be put in place to ensure that all relevant staff are trained, and knowledgeable Assessments, Diagnosis, Treatment, and Crisis plans. Staff will also be trained in how to better meet the needs of the clients by understanding the client's diagnosis so they can better assist the client through the recovery process. All relevant staff will be trained on the consumer's treatment plan and how important it is to understand their client's goals and goals change as the client progresses through treatment.	Managing Member Corporate compliance Clinical Director Therapist HR Manager	Completed by 15th February 2020

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V 131	**Element** G.S. 131E-256 (D2) HCPR - Prior Employment Verification **Standard** G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. **Deficiency/ Finding** This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to employment for 2 of 6 audited staff (the Office Manager and the Qualified Professional (QP)). The findings are: Review on 12/20/19 of the Office Manager's personnel file revealed: -A hire date of 11/10/17; -No documentation that the HCPR was accessed prior to employment. Review on 12/20/19 of the QP's personnel file revealed: -A hire date of 5/29/17; -No documentation that the HCPR was accessed prior to employment. Interview on 12/20/19 with the Licensee revealed: -She was aware that the HCPR was required to be accessed prior to employment; -She wasn't aware the the HCPR wasn't accessed prior to the employment of the Office Manager and the QP; -It was the responsibility of Human Resources to ensure that the HCPR was accessed prior to employment of all staff.	V 131	The HR Manager will Review G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY The HR Manager will sign the necessary document attesting that the HR Manager has Read and Understood the above-mentioned standard The HR Manager will ensure that prior to any new hire that the HR Manager will check the Personal Health Care Registry The HR Manager will Review and Audit all HR charts and ensure that they all contain the Health Care Personal Registry. The HR Manager will ensure that all current HR Charts have the results from the Health Care Personal Registry HR shall make sure all employees have a written job description that specifies the minimum level of education, duties and responsibilities, and signed by the staff member and supervisor and/or HR . HR shall make sure that all employees are at least 18 years of age, able to read, write, and understand and follow directions. HR shall make sure that no employee has no findings of abuse and/or neglect as listed on the NC Health Care Registry. HR shall make sure all new employees who are from out of state within 5 years complete a national background check along with fingerprinting prior to starting employment.	HR Manager Managing Member Corporate Compliance	Completed by 31st January 2020 Completed by 8th February 2020 Completed by 15th February 2020

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V 268	**Element** 27G .4403 Sub. Abuse Intensive Outpt – Operations **Standard** 10A NCAC 27G .4403 Substance. Abuse Intensive Outpatient – OPERATIONS (a) A SAIOP shall operate in a setting separate from the client's residence. (b) Each SAIOP shall operate at least three hours per day, at least three days per week with a maximum of two days between offered services. (c) A SAIOP shall provide services a maximum of 19 hours for each client. (d) Each SAIOP shall provide services a minimum of nine hours per week for each client. (e) Group counseling shall be provided each day program services are offered. (f) Each SAIOP shall develop and implement written policies to carry out crisis response for their clients on a face to face and telephonic basis 24 hours a day, seven days a week, which shall include at a minimum the capacity for face to face emergency response within two hours. (g) Before discharge, the program shall complete a discharge plan and refer each client who has completed services to the level of treatment or rehabilitation as specified in the treatment plan. **Deficiency/Finding** This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete a discharge plan and refer a client who had completed services based on their treatment plan affecting 1 of 1 former clients ((FC) #4). The findings are: Review on 12/20/19 of FC #4's record revealed: -An admission date of 10/29/19; -No documentation of a discharge date or a discharge plan; -Diagnoses included Opioid Use Disorder, Alcohol Use Disorder, Cocaine Use Disorder, Nicotine Use Disorder, Benzodiazepine Use Disorder, Crystal Methamphetamine Use Disorder, Major Depression, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder and Hypertension; -A treatment plan dated 10/29/19 included goals of, "will adhere to the requirements of medication assisted treatment to include participation in random drug screenings, abstinence from the use of opioids, and attending individual/group therapy sessions...will take medication as prescribed...will decrease anxiety and depressed mood as well as anger as evidenced by utilizing positive coping strategies and stress management techniques...;" -Substance abuse intensive outpatient program (SAIOP) group notes that indicated FC #4 had attended on 10/30/19, 11/1/19, 11/4/19, 11/6/19, 11/8/19, 11/11/19, 11/13/19, 11/18/19, 11/20/19, 11/25/19, 11/27/19, 12/2/19, 12/4/19, 12/6/19, 12/11/19, and 12/19/19. Attempts in interview FC #4 were not successful because he failed to return telephone calls. Interview on 12/23/19 with the Licensee revealed: -FC #4 had been moved from SAIOP to outpatient therapy; -She thought a discharge plan didn't have to be completed since FC #4 was still going to be receiving outpatient therapy services from the facility; -She wasn't aware that FC #4's treatment plan should have been updated prior to his discharge from SAIOP.	V 268	Clinical Director and Therapist and other relevant staff will review and discuss 10A NCAC 27G .4403 Substance. Abuse Intensive Outpatient – OPERATIONS The relevant staff will sign and attest that they have read and understood the guidelines. An Internal Referral Form will be created so that documentation is clear for when clients are referred from one level of care to another within the agency Therapist will ensure that Treatment plans are updated to reflect change in client goals and services, Charts will be audited to ensure that clients within the agency have been referred appropriately	Managing Member Corporate compliance Clinical Director Therapist HR Manager	Completed by 8th February 2020

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V 536	**Element** 27E .0107 Client Rights - Training on Alt to Rest. Int. **Standard** 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at anytime. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.	V 536	Corporate compliance will review 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS HR will ensure that all staff are aware of the necessary trainings that must be completed to keep the staff in compliance. HR will inform staff of Training Schedule HR will inform staff of trainings that are needed per role definition HR will also ensure that clinical staff are keeping up to date with their required CME's Staff Trainings in Alternatives to Restrictive has been scheduled for the 22nd and 29th January 2020 When New Staff are hired, HR will discuss trainings needed for staff to be incompliance with New staff during orientation. HR will document with New Hire which trainings that New Hire will be responsible for and which trainings RAPHA will be responsible for completing	Managing Member HR Manager Corporate Compliance	Completed by 15th February

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V 536	**Deficiency/Finding** This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 4 current staff (the Site Supervisor, the Medical Assistant, the Qualified Professional (QP) and the Office Manager) had current training in the use of alternatives to restrictive interventions. The findings are: Review on 12/20/19 of the Site Supervisors personnel record revealed: -A hire date of 1/22/18; -No documentation that training on alternatives to restrictive interventions had been completed. Review on 12/20/19 of the Medical Assistants personnel record revealed: -A hire date of 7/24/19; -No documentation that training on alternatives to restrictive interventions had been completed. Review on 12/20/19 of the QP's personnel record revealed: -A hire date of 5/29/17; -No documentation that training on alternatives to restrictive interventions had been completed since 1/12/17. Review on 12/20/19 of the Office Manager's personnel record revealed: -A hire date of 11/10/17; -No documentation that training on alternatives to restrictive interventions had been completed since 1/18/17. Interview on 12/20/19 with the Office Manager revealed she didn't realize that a former refresher training was required to be completed annually. Interview on 12/20/19 with the Licensee revealed: -Training on alternatives to restrictive interventions was scheduled to be completed in January of every year; -She was aware that the Medical Assistant had not completed the training, but she was not aware that the Site Supervisor, the QP and the Office Manager had not completed the training in January.	V 536	Staff Trainings in Alternatives to Restrictive has been scheduled for the 22nd and 29th January 2020 HR Manager will ensure that certificate is placed in the file of all staff Staff will be informed of All other Relevant staff trainings for 2020	Managing Member Corporate compliance HR Manager	Completed by 7th February 2020