STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 follow-up survey was completed on 1/23/20. Deficiencies were cited. Current census in this 3600 program was 114. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.	V 000	DHSR - Mental Health FEB 17 2020 Lic. & Cert. Section	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 2 governing body failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. The findings are: Cross Reference: 10A NCAC 27G.0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review and interviews the facility failed to ensure that 2 of 3 paraprofessionals (Treatment Center Director (TCD) and Former TCD) demonstrated knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G.0205(a) Assessment and Treatment/Habilitation or Service Plan (V111). Based on interview and record review, the facility failed to develop and implement strategies prior to the delivery of services to address the client's presenting problem for 11 of 11 audited clients (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11). Cross Reference: 10A NCAC 27G.0205(c) Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interviews the facility failed to develop and implement treatment plans within 30 days of admission effecting 10 of 11 audited clients (Clients #1, #2, #3, #5, #6, #7, #8, #9, #10, #11). Cross Reference: G.S. 131E-256 Health Care Personnel Registry (V131). Based on record review and interviews, the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 1 of 3 audited staff (Counselor #3). Cross Reference: 10A NCAC 27G .3601 (V233).	V 105	A supervision form that documents the supervision of any paraprofessional will be completed and placed in the HR file of the paraprofessional . This will be done by either the Regional Vice President, Regional Director of Operations or Corporate Compliance Officer. This will be done annually in conjunction with the annual performance evaluations. This has been discussed with the entire staff as the requirements and content on multiple occassions since the survey was conducted. The completion of the assessments will be ensured by chart audits that are to be completed by the Treatment Center Director, Clinical Supervisor and Regional Compliance Officer. These audits will ensure that the assessments are done within the guidelines outlined in 10A NCAC 27G.0205. Access to the previous Electronic Medical Records has been re-established and all records are available for the staff. This task has been added to the onboarding process required for any new hire in North Carolina. This will also be confirmed by the Treatment Center Director and kept in the employee's personnel file. No employee will be allowed to start work without having the HCPR ran and the results providing no past conduct that would bring the employee's ability to make ethical decisions in the normal course of the duties they are being hired to perform.	1/28/2020 1/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 3 Based on record reviews and interviews, the facility failed to provide coordination of care with medical providers for 4 of 11 audited clients (Clients #1, #5, #8 and #11). Cross Reference: 10A NCAC 27G .3603 Staff (V235). Based on record review and interviews, the facility failed to ensure all staff received continuing education to include understanding of the nature of addition, withdrawal syndrome, group and family therapy and infectious diseases for 2 of 3 audited staff (Treatment Center Director (TCD) and Counselor #3). Cross Reference: 10A NCAC 27G .3604 Outpatient Opioid Treatment Operations (V238). Based on record reviews and interviews, failed to ensure that during the first year of continuous treatment each client attended a minimum of two counseling sessions per month and after the first year of treatment attended at least one counseling session per month for 5 of 11 audited clients (Clients #1, #2, #6, #7, #11); failed to conduct a minimum of one random urine drug screen (UDS) each month for 2 of 11 audited clients (Clients #8, #10); failed to ensure that one drug test per 3 month period was observed for 9 of 11 audited clients (Clients #1, #2, #3, #4, #5, #7, #8, #10, #11) and failed to ensure 9 of 11 audited clients (Clients #1, #2, #3, #5, #6, #7, #8, #10 and #11) were not dually enrolled within a 75 miles radius. Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536). Based on personnel record review and staff interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention prior to providing services for 3 of 3 audited staff (Treatment Center Director	V 105	A manual log has been created that provides an additional system for following up on Contunity of Care and Coordination of Care cases. The RegionalCompliance Officer will work with the Clinical staff to develop and improve the Electronic Medical Records system if required to facilitate an improved system that enables easier tracking of any Contunity of Care or Coordination of Care cases. Additional training was added to the Relias training making it a requirement for all North Carolina employees. This training includes nature of addiction, withdrawl, group and family therapy and infectious diseases. This completion of this traininig will be automaticaly monitored by the Relias system and a failure to complete this training will result in the employee not being allowed to work until they have completed the training. A Maunal log was created and is maintained by the administrative staff that requires each required patient's UDS is completed within the time frame outlined in 10A NCAC 27G.3604 Training was conducted on 1/23/2020 and again on 2/11/2020 in regards to the dual enrollment form, how to fill it out and where to send it. These forms will be kept and stored accordingly. Additional training was added to Relias for all North Carolina employees as referenced above.	2/11/2020 1/31/2020 1/23/2020 1/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 4 (TCD), Licensed Practical Nurse (LPN) and Counselor #3). Review on 1/16/20 of "Criteria for Admission" Policy revealed: -" ...To ensure that patient care is in alignment with high-quality individualized medical care and in compliance with applicable regulations, all applicants will be screened for appropriateness of detoxification or maintenance treatment and key potential patient care risks will be identified and addressed during the performance and documentation of the admission history and physical exam ...." Finding #1: Facility failed to ensure standards of operational practice were followed. Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -There was no History and Physical exam in the record. Record review on 1/15/20 for Client #2 revealed: - Admitted on 9/22/17 with diagnosis of Opioid Use Disorder. -There was no History and Physical exam in the record. Record review on 1/15/20 for Client #3 revealed: - Admitted on 4/13/18 with no identified diagnosis documented in the record. -There was no History and Physical exam in the record. Record review on 1/15/20 for Client #4 revealed: - Admitted on 4/13/18 with diagnoses of Opioid Use Disorder, Hep C, Type II Diabetes, Morbid Obesity and Sleep Apnea.	V 105	The Electronic Medial Record system was restored and access to the previous EMR was restored providing the documentation that details the admission history and physical exam was completed. In addition, paper versions of the forms have been printed and the staff trained as to their existence. This will ensure that in the event that the EMR expereinces a disruption, the clinic can revert to paper documentation to ensure the patients do not experience any disruption of their treatment. Ref. above Ref. above Ref. above Ref. above	2/11/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 5 -There was no History and Physical exam in the record. Record review on 1/16/20 for Client #6 revealed: - Admitted on 2/16/18 with diagnosis of Chiari malformation. -There was no History and Physical exam in the record. Record review on 1/16/20 for Client #7 revealed: - Admitted on 1/25/19 with no identified diagnosis documented in the record. -There was no History and Physical exam in the record. Record review on 1/16/20 for Client #8 revealed: - Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). -There was no History and Physical exam in the record. Record review on 1/16/20 for Client #9 revealed: -Admitted on 9/13/19 with diagnosis of Opioid Use Disorder. -There was no History and Physical exam in the record. Record review on 1/16/20 for Client #10 revealed: - Admitted on 8/11/17 with no identified diagnosis documented in the record. -There was no History and Physical exam in the record. Record review on 1/16/20 for Client #11 revealed: - Admitted on 3/1/19 with diagnosis of Opioid Use Disorder -There was no History and Physical exam in the record.	V 105	Ref. previous corrective action pg. 5 Ref. previous corrective action pg. 5 Ref. previous corrective action pg. 5 Ref. previous corrective action pg. 5 Ref. previous corrective action pg. 5 Ref. previous corrective action pg. 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 6 Finding #2: Facility failed to ensure physician signed orders within 72 hours. Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -60 milligrams (mg) of Methadone was ordered on 11/23/19 and signed by the physician on 12/5/19. -70mg of Methadone was ordered on 11/27/19 and signed by the physician on 12/5/19. Record review on 1/16/20 for Client #5 revealed: - Admitted on 10/5/19 with no identified diagnosis documented in the record. -65mg of Methadone was ordered on 11/20/19 and signed by the physician on 12/5/19 with a note on the order: "computer server down-verbal order." Interview on 1/15/20 with the Licensed Practical Nurse (LPN) revealed: -She was lead nurse and worked at the facility since 8/30/18. -The company switched EMR (electronic medical record) systems on 6/18/19. The only information imported was the most recent orders and the UDS (urine drug screens) The following information was not imported --medical --labs (bloodwork) --original orders --history and physicals --assessments --treatment plans She realized the first of July the previous work could not be obtained and called [previous EMR system] herself but the call was never returned. -She told [the former Treatment Center Director	V 105	The EMR was restored allowing the orders to be signed within the required timeline. The Medical Director will have access to the EMR allowing for the review and timely signing of orders as required. This has been discussed with the Medical staff on multiple occassions to ensure that everyone fully understands the perameters. It was also discussed that in the event where the Medical Director can't sign a new order, the previous order will remain in effect. Ref. above. Access to the previous EMR in addition to the current EMR being restored allows the Medical Staff the ability to access all records.	1/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 7 (TCD)] as well as [the Regional Director] in Texas "but nothing happened." -The delay in the physician signing orders electronically was due to the EMR not being operational from approximately 11/14/16 through 12/5/19. -No paper prescriptions were written during this time. No changes to doses were allowed up or down and no take homes were given. -Reported to administration and the corporate Information Technology (IT) department were notified of the EMR being non-functional. Interview on 1/15/20 with Counselor #3 revealed: -The Regional Vice President came to the facility the first of October 2019 to announce the TCD was coming back and the former TCD was gone. -She and Counselor #2 told him documents were disappearing. He told them it was the first he had heard of it. Interview on 1/16/20 with the TCD revealed: -The company switched Electronic Medical Record Systems mid-June 2019. -She started at the clinic the first of October 2019. -Had contacted her "Regional" about problems with systems issues. She was just trying to keep billing. She got a few plans but it was hit and miss showing up in the new system. She was waiting on IT to get everything uploaded to the new system. -"It was non-stop chaos since we began in the new system." -"It takes forever to navigate through the new system." -"And then the whole system crashed in November-we couldn't enter notes and had to hand write administration record for each client. Everyone had to dose daily-couldn't do take homes."	V 105	Ref. previous action noted on page 7. The RVP was made aware of documents not being in the system where they could be accessed. This was discussed with the Corporate IT department and the IT dept. was unable to identify any specific incidents where the documents were missing. Since the restoration, this has not reoccured and all documents in are accessable. 1/23/2020 Improvements were made to the EMR with weekly calls taking place that incorporated best practices from every region. This helped create an EMR that was ever evolving and improving. The restored EMR has multiple improvements that prevent the user from completing a document without the document being complete. This combined with the manual procedures implimented will ensure that the clinic is compliant with the noted regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 8 -"Really didn't know how big this system problem was until now." Review on 1/22/20 and 1/23/20 of Plan of Protection signed by the Regional Vice President (RVP) revealed: "V118- Medication Requirements: Access to the previous Electronic Medical Records (EMR) is being working at this time by the Corporate CIO (Chief Information Officer) to allow access to those records by on site staff. The information will be accessible to the staff NLT [No Later Than] 1/23/2020. V105-The entire staff was trained on the exact procedure for any new admission. This training covered every department so the entire staff was aware of the different responsibilities for clinical, medical and administrative. This training was conducted 1/22/2020. V105-Training will also be conducted on assessments using the Clinical Opiate Withdrawl Symptoms (COWS) to include when the assessments will be done, recorded and who is responsible for doing them. Treatment Center Director [TCD] will ensure that no adjustments will be done without assessments being completed prior to and ongoing after the training is completed. V105-Additional training was added to [electronic learning system] for the staff to complete in order to be compliant. This training includes HIV, Opioid Withdrawal, Restrictive intervention and Group and Individual Treatment. This will be uploaded NLT 1/24//2020 and the staff will be required to have it completed NLT the 1/31/2020.	V 105	Access was given to the staff and a followup was also discussed during a staff meeting on 2/11/2020 and 2/12/2020. Both EMR's are being utilized until all past information can be successfully imported into the current EMR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 9 V105-Urine Drug Screens (UDS) will require a manual log to be maintained by the administrative staff and the TCD will ensure that each patient is compliant with the requirements. The current EMR system for random UDS will continue to be utilized with the manual process being secondary to ensure 100% compliance. This will begin the week of 1/26/2020 and the creation of the list and training will begin 1/22/2020. V105- UDS observed screens quarterly will be done according to regulations and tracked using the UDS manual log. In the case where no male employee is available to observe a male patient a male employee from [sister facility] will travel to the Murphy clinic no less than once a month to ensure the quarterly requirement is met. V131- [Licensee] corporate HR [Human Resources] was made aware of the deficiency and this will be added to the onboarding packet for any and all North Carolina new hires. This was communicated with HR on 1/22/2020 and will be included from this date moving forward. The TCD will conduct this until HR can ensure it will be included in the onboarding packet. V238- Dual enrollment forms will be faxed and central registry information will be entered as a part of the pre-admission process. These forms will be kept in a file by the administrative staff. This is effective immediately and will be conveyed to the staff on training conducted on 1/22/2020 to include who is responsible for completing and ensuring it is done. V110- Prior to hiring any para-professional, the candidate will be assessed to ensure that they meet the competency requirements as outlined in 10ANCAC27G.0204 paragrah a-f. This will be	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 10 documented and maintained in the personel file on site. This will also be done for current employees that do not currently have the documentation and completed NLT 31JAN2020. V233- Training will be conducted on the proper procedure and documentation on any and all orders. This training will be conducted on 1/23/2020 ensure that all medical staff will be able to attend. This training will also explain where the responsiblity lies for the required documentation for an order. Training will be conducted for all staff on 1/22/2020 and on 1/23/2020. On-line training will be available and required for completion by 1/31/2020. I will make regular visits to the clinic throughout the process to ensure the proper procedures are being followed to include the additional processes added to ensure compliance. I will work with corporate compliance to schedule on-site compliance visits on a more frequent basis moving forward. V118- the MD [medical director] orders will be given to the nurse to input into the system for the MD to sign. The nurse that receives the order is responsible for ensuring the MD signs them in the appropriate time frame. This will be the same nurse that completes the assesments prior to going to the MD for a decision. The MD will have a laptop allowing access to the EMR remotely as well. A report will be pulled by the nurse and verified by the TCD weekly to ensure that all orders are signed and being followed. This was discussed in training conducted on 1/22/2020 and will be covered again on 1/23/2020 with any staff that was not present on 1/22/20. V233- Coordination of care (COC) responibility	V 105	Completed and placed in the PP personel file. Training reviewed on 2/12/2020 On-line training is available for entire staff Reviewed again on 2/12/2020	1/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 11 will be divided in regards to Social Services and Medical Services. The Clincal staff will be responsible for the COC for and social services and the Medical Services for any Medical COC responsibilities that occur. This will be determined specifically by the case load or Medical Personel that is receiving the order from the MD. Any patient that has a COC issue that covers both Social and Medical will be discussed in treatment team when necessary to ensure that both aspects are addressed and followed up on and coordinated as well. This was discussed on training on 1/22/20 and a manual tracking mechanism was created on 1/22/20. This product will be refined as we move forward and cocurring accountablity within the EMR will be utilized to ensure any COC issues are captured. V238- The UDS manual log will be maintained at the front administration area and the TCD will be responsible for subsquent checks to ensure complaince. This log will cover any and all sub catageories such as observed and required monthly checks. Clinical sessions will also be monitored manually by caseload with the Clinical Supervisor bearing the responsiblity of ensuring the required sessions are done. In the abscence of a Clinical Supervisor, the TCD will be responsible for the verification via the manual reporting method. This was communicated during all staff training on 1/22/20 and the manual product is being developed. The EMR reporting will also be utilized to ensure compliance and when it is determined by the RVP and TCD that the manual reporting is no longer necessary, it will return as the primary method for accountability in the clinical sessions per month.	V 105	Ref. corrective action Pg. 4 and reviewed again on 2/12/2020. This will be on-going as to the improvment of the effectiveness of any COC related issue. The TCD will contunie to do outreach strengthening the network of providers we refer our patients to for services outside our scope or capability. Reviewed 2/11/2020 Reviewed 2/12/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 12 IT [information technology] related fixes- I am aware that the protection and subsquent recovery from another IT related disruption has been a major point of emphasis for not only the CIO and IT department but the rest of the Company's senior leadership too. The specifics of any new safeguards in regards to either protection or recovery have not been relayed to me at this time. I will present this question to the CIO and relay to you the detailed plan as soon as I know. V110- Any Para-professional employed at the clinic will be supervised by the Regional Director of Operations (RDO) and in the case where an RDO is not avaiable, the Regional Vice President (RVP) will assume responsiblity of any and supervison of paraprofessional at the clinic level. The undersigned as the RVP is currently responsible for the supervision of the TCD in Murphy." The facility failed to implement their governing body policy for "Criteria for Admission" by not providing admitting history and physical exams to confirm eligibility to receive methadone assisted treatment for 10 of 11 clients, while 4 of 11 clients had no identified diagnosis. The facility also failed to complete clinical assessments for 11 of 11 clients and failed to ensure development of treatment plans with specific strategies and interventions to address treatment needs for 10 of 11 clients. Coordination with community medical and mental health professionals could not be verified for clients with Hep C, Type II Diabetes, Depression, Anxiety, morbid obesity, GERD and sleep apnea. 5 of 11 clients failed to receive the required number of counseling sessions. 2 of 11 clients failed to receive monthly UDS and 9 of 11 clients failed to have quarterly observed UDS. The facility failed to confirm	V 105	As per the Corporate CIO, the IT department added secondary datacenter with failover capabilites, replaced desktop security tools with advanced threat protection to prevent new/future virus attacks, replaced network firewalls to provide greater security, added secondary internet links to provide internet backup during outages and implimenting manual procedures to ensure business continunity. 1/23/2020 Ref. page 3 corrective action Ref. corrective action pg. 4 and pg. 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 105	Continued From page 13 non-dual enrollment within a 75-mile radius for 9 of 11 clients currently receiving methadone assisted treatment. The facility failed to complete 1 counselor's HCPR check at date of hire and 2 of 3 staff failed to complete the required Substance Use Disorder continuing education. Despite changing EMR systems in June of 2019, there were no strategic plans from either the former TCD nor the current TCD to access critical clinical and/or medical information from their own system about each client served. Failure to maintain fully trained staff and implement policies critical to safety and systemic failures within the scope of the program which resulted in serious neglect and constitutes a Type A1 rule violation and must be corrected within 23 days. An administrative penalty of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 105	Protocols are in place, staff has been trained and all medical information is available. The TCD is aware of the process should any future disruption to the EMR happen.	
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking,	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 110	Continued From page 14 then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 2 of 3 paraprofessionals (Treatment Center Director (TCD) and Former TCD) demonstrated knowledge, skills and abilities required by the population served. The findings are: Record review on 1/16/20 for TCD revealed: -Date of hire was 8/19/19. -GED 3/18/91. Record review on 1/22/20 for Former TCD revealed: -Date of hire was 11/11/18. -Date of termination: 10/1/19. -Associates degree 12/2012.	V 110	A supervision session was conducted and documented on 1/29/20. A copy of this was placed into the TC's personnel file and the supervisor maintains a copy.	1/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 110	Continued From page 15 Interview on 1/16/20 with Counselor #3 revealed: -Had worked there since 4/23/19. -Felt that former TCD "was in over her head" as program manager. -"The push was to increase census." -Told the Former TCD multiple times that they could not get their previous documents including assessments, treatment plans or notes out of the system. The Former TCD had no plans to recreate assessments or plans. -"Told [former TCD] the client information [including assessments, treatment plans or notes] in system [in EMR (electronic medical record)] was disappearing and needed to be moved forward before it was gone." -Had EMR trainers on 6/11/19-6/14/19 who said they would be able to get their documents from the old system and then said "no you'll just have to recreate them." -Sent email to Former TCD and Corporate Clinical Training Manager asking for direction for record keeping of treatment plans and psychosocials. Asked if they could be printed from the old system and scanned into new system, specifically original treatment plans and assessment and any or all updates. -Email back from Clinical Training Manager supporting their efforts and understanding their frustrations as well as informing her boss. -Received an email from the Former TCD regarding behavioral concerns which Counselor #3 felt was retribution for complaining to corporate office about system changes. -"Signature pads don't work." They may have had treatment plan but clients couldn't sign them. -"If plans were printed from the old system, the scanner did not work so there was no uploading to the new system." -There were no systems put into place to	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 110	Continued From page 16 streamline processes from intake to documenting daily counseling notes since mid-June. And then "the new EMR was awful-much worse than previous system" which increased frustration. Interview on 1/16/20 with TCD revealed: -Had contacted the corporate IT (information technology) department to seek assistance with accessing documents from the old system. -Got a few treatment plans that would show up in the old system but waited on IT to get everything uploaded to new system. -The whole system crashed from malware infection in November. Staff could not enter notes and clients had to dose daily which was documented on paper. -Still waiting on corporate office and IT to fix the system. -Was just trying to keep everyone happy so they wouldn't leave. This deficiency is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 110	Current EMR system is fully functioning and allows for everything to be completed within the required timeline. A manual system is also in place in the event of a major EMR disruption which will ensure that any and all documentation will be done accordingly.	
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT 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	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 111	Continued From page 17 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. (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.	V 111		
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assess client's presenting problems, needs and strengths, admitting diagnosis, pertinent social, family or medical history or previous evaluations pertinent to client needs for 11 of 11 audited clients (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11). The findings are:		Ref. pervious correction pg. 5	
	Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -There was no clinical assessment in the record.		Ref. previous correction pg. 5	
	Record review on 1/15/20 for Client #2 revealed: - Admitted on 9/22/17 with diagnosis of Opioid			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 111	Continued From page 18 Use Disorder. -There was no clinical assessment in the record.	V 111		
	Record review on 1/15/20 for Client #3 revealed: - Admitted on 4/13/18 with no identified diagnosis documented in the record. -There was no clinical assessment in the record.		Ref. previous correction pg. 5	
	Record review on 1/15/20 for Client #4 revealed: - Admitted on 4/13/18 with diagnoses of Opioid Use Disorder, Hep C, Type II Diabetes, Morbid Obesity and Sleep Apnea. -There was no clinical assessment in the record.		Ref. previous corrections pg. 5	
	Record review on 1/16/20 for Client #5 revealed: - Admitted on 10/4/19 with no identified diagnosis documented in the record. -There was no clinical assessment in the record.		Ref. previous corrections pg. 5	
	Record review on 1/16/20 for Client #6 revealed: - Admitted on 2/16/18 with diagnosis of Chiari malformation. -There was no clinical assessment in the record.		Ref. previous corrections pg. 5	
	Record review on 1/16/20 for Client #7 revealed: - Admitted on 1/25/19 with no identified diagnosis documented in the record. -There was no clinical assessment in the record.		Ref. previous corrections pg. 5	
	Record review on 1/16/20 for Client #8 revealed: - Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). -There was no clinical assessment in the record.		Ref. previous corrections pg. 5	
	Record review on 1/16/20 for Client #9 revealed: -Admitted on 9/13/19 with diagnosis of Opioid Use Disorder. -There was no clinical assessment in the record.		Ref. previous corrections pg. 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 111	Continued From page 19 Record review on 1/16/20 for Client #10 revealed: - Admitted on 8/11/17 with no identified diagnosis documented in the record. -There was no clinical assessment in the record. Record review on 1/16/20 for Client #11 revealed: - Admitted on 3/1/19 with diagnosis of Opioid Use Disorder. -There was no clinical assessment in the record. Interview on 1/16/20 with Counselor #3 revealed: -"Told [former Treatment Center Director (TCD)] the client information in system [electronic medical record] was disappearing and needed to be moved forward before it was gone." -Psychosocial assessments were completed at intake. They were in the system-just couldn't get them out. Interview on 1/16/20 with the contracted Clinical Supervisor revealed: -Met with counselors twice monthly to provide their required clinical supervision. -Counselors did not have access to the facility's previous Electronic Medical Record (EMR) for the past five months to review client information and documentation. -Had called the facility's Information Technology (IT) Department five times in five months and could not get through to a representative and received no return calls. -There was no defined role as to who does client intakes. This led to confusion on whose role it was to complete required documentation. -Advised counselors to document why they could not meet documentation requirements. Interview on 1/16/20 with the LPN (Licensed Practical Nurse) revealed:	V 111	Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Access to both the current and previous EMR has been restored.	1/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 111	Continued From page 20 -She was lead nurse and "had worked at the facility since 8/30/18." -The company "switched EMR (electronic medical record) systems on 6/18/19 ...No assessments were imported ..." Interview on 1/16/20 with TCD revealed: -The company switched EMR systems mid-June 2019. -She started at the clinic the first of October 2019. -Had contacted her "Regional" about problems with systems issues. -"Really didn't know how big this system problem was until now." This deficiency is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 111	Ref. previous corrections pg. 5 Access to both EMR systems was restored and data that is stored in the previous EMR will be copied to the current EMR in addition to maintaining access to previous EMR.	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 112	Continued From page 21 responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement treatment plans within 30 days of admission effecting 10 of 11 audited clients (Clients #1, #2, #3, #5, #6, #7, #8, #9, #10, #11). The findings are: Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -No signed treatment plan was presented. Record review on 1/15/20 for Client #2 revealed: - Admitted on 9/22/17 with diagnosis of Opioid Use Disorder. -No signed treatment plan was presented. Record review on 1/15/20 for Client #3 revealed: - Admitted on 4/13/18 with no identified diagnosis documented in the record. -No signed treatment plan was presented. Record review on 1/16/20 for Client #5 revealed: - Admitted on 10/4/19 with no identified diagnosis documented in the record. -No signed treatment plan was presented.	V 112	Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 112	Continued From page 22 -Counseling note for Client #5 dated 10/18/19 stated they were "aware that the psychosocial assessment and treatment plan are out of compliance due to circumstances of the intake process." Record review on 1/16/20 for Client #6 revealed: - Admitted on 2/16/18 with diagnosis of Chiari malformation. -No signed treatment plan was presented. Record review on 1/16/20 for Client #7 revealed: - Admitted on 1/25/19 with no identified diagnosis documented in the record. -No signed treatment plan was presented. Record review on 1/16/20 for Client #8 revealed: - Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). -No signed treatment plan was presented. Record review on 1/16/20 for Client #9 revealed: -Admitted on 9/13/19 with diagnosis of Opioid Use Disorder. -No signed treatment plan was presented. Record review on 1/16/20 for Client #10 revealed: - Admitted on 8/11/17 with no identified diagnosis documented in the record. -No signed treatment plan was presented. Record review on 1/16/20 for Client #11 revealed: - Admitted on 3/1/19 with diagnosis of Opioid Use Disorder -No signed treatment plan was presented. Interview on 1/15/20 with Counselor #3 revealed: -"Told [former Treatment Center Director (TCD)]	V 112	Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 112	Continued From page 23 the client information [in EMR (electronic medical record)] was disappearing and needed to be moved forward before it was gone." - 30-day plans were completed at intake but clients couldn't sign them because the electronic signature pads didn't work. -90-day plans were also completed which had more specific personal goals, but clients still couldn't sign the plans. -There was no guidance on how or when to complete treatment plans. -The new system would auto-populate goals with strategies but could not be amended. Interview on 1/16/20 with the LPN (Licensed Practical Nurse) revealed: -She was lead nurse and "had worked at the facility since 8/30/18." -The company "switched EMR (electronic medical record) systems on 6/18/19...No treatment plans were imported ..." Interview on 1/16/20 with TCD revealed: -"Plans were done we just can't get them out of the system." Interview on 1/16/20 with TCD revealed: -The company switched EMR systems mid-June 2019. -She started at the clinic the first of October 2019. -Had contacted her "Regional" about problems with systems issues. -"Really didn't know how big this system problem was until now." This deficiency is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 112	Ref. previous corrections pg. 5 Ref. previous corrections pg. 5 Ref. previous corrections pg. 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 24	V 118		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications and take-home	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 25 doses of medication were administered on the written order of a physician for 3 of 11 audited clients (#1, #6, #11) and that the Medication Administration Records (MAR) were kept current and accurate for 11 of 11 audited clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11). The findings are: Finding #1: The Facility failed to ensure medications and take-home methadone doses were administered on the written order of a physician. Review on 1/15/20 of the record for Client #1 revealed: -Admitted on 3/20/19 with diagnoses of Opioid Use Disorder. -Physician verbal order dated 11/23/19 for 60 mg Methadone to begin 11/16/19. -There was no physician order for 60 mg Methadone to cover from 11/16/19 until a new verbal order was given on 11/23/19. -Physicians verbal order for 70 mg dated 11/23/19. Review on 1/15/20 of Client #1's MAR from October 2019-December 2019 revealed: -11/16/19 to 11/28/19 - 60mg Methadone. -11/29/19 to 12/2/19 - 70mg Methadone. -The 11/23/19 Physicians order to increase the methadone dose from 60 mg to 70 mg was not followed until 11/29/19. Review on 1/16/20 of the record for Client #6 revealed: -Admitted on 2/16/18 with diagnosis of Chiari malformation. Review on 1/16/20 of Client #6's MAR from October 2019-December 2019 revealed:	V 118	Represenatives from the Corporate IT department have been on site and worked with the Medical Staff to reconcile the MAR report for all patients. The Medical Staff has also been trainined on the proper procedures to follow to in the event of an IT disruption. Those procedures will ensure that the orders will be followed and that there will be no impact to the patients. The EMR system that contains the orders has been restored Ref above	1/31/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 26 -Client began Code 1 take homes of 80mg (code 1=client to attend the clinic one time per week) on 11/26/19 with no physician order. -The latest physician order available was dated 8/17/19 and ordered Code 6 of 80mg (attending the clinic 6 days per week). Review on 1/15/20 of the record for Client #11 revealed: -Admitted on 3/1/19 with a diagnosis of Opioid Use Disorder. -Urine drug screen (UDS) results for 9/11/19 were positive for amphetamines. -UDS results identified 6 additional, consecutive dates as positive (Pos.) for benzodiazepines: 10/21/19, 10/28/19, 11/25/19, 12/9/19, 12/23/19, and 1/8/20. -Physician order dated 9/27/19 stated: "Pos. 9/11/2019" and "Suggest drop 1 take home due to illicit." -Physician order dated 9/30/19 stated: "Suggest 1 take home decrease. State regs state warning for first illicit then take home to be taken." -Physician order dated 10/12/19 stated: "She will lose take homes if continued RX are not verified." -Counseling note dated 11/5/19 stated: "Patient has illicit UDS for Benzos and RX has expired." Review on 1/15/20 of Client #11's MAR from October 2019-December 2019 revealed: -The 11/18/19 through 11/22/19 MAR evidenced the client missed 5 daily doses of Methadone during this time frame. -Paper records kept by the Licensed Practical Nurse (LPN) from 11/18/19 through 11/22/19 documented that the client received the correct daily dose of 20 mg during this timeframe. -Take home doses were documented on the MAR as 3 take home doses per week from 9/26/19 through 12/19/19 when they increased to 4 take	V 118	Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 27 home doses per week. -Take home doses were not decreased or taken away by 1 take home dose per the physician's orders dated 9/27/19, 9/30,19 and 10/ 12/19. Interview on 1/16/20 with the LPN regarding Client #11's take home doses not being decreased per physician orders revealed: -There was no designated person to ensure physician orders get followed. Anyone can read the orders and follow them, to include counselors, RNs, and LPNs. -Counselors talk to clients about drug screens and could recommend changes to take home doses. -Client needed to be looked at for compliance with the benzodiazepine use policy. Client was on Buprenorphine and it's not part of the Benzodiazepine and Methadone policy. -Client didn't lose take homes with consistent positive USDs because she was on Buprenorphine and not Methadone. -"There is no negative reaction between the two (Buprenorphine and Benzodiazepine) that I know of." Finding #2: MARs were not kept current and accurate. Review on 1/15/20 of the record for Client #1 revealed: -Admitted on 3/20/19 with diagnoses of Opioid Use Disorder. Review on 1/15/20 of Client #1's MAR from October 2019 through December 2019 revealed: -The 11/15/19 through 11/17/19 Methadone doses evidenced a prepared-on date of 1/7/20 after the administration date (3 doses).	V 118	Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26	1/31/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 28 - The 11/18/19 through 11/22/19 Methadone doses evidenced a prepared-on date of 12/23/19 after the administration date (5 doses). Review on 1/15/20 of the record for Client #2 revealed: -Admitted on 9/22/17 with diagnoses of Opioid Use Disorder. Review on 1/15/20 of Client #2's MAR from October 2019 through December 2019 revealed: -The 11/15/19 through 11/17/19 Methadone doses evidenced a prepared-on date of 1/7/20 after the administration date (3 doses). - The 11/18/19 through 11/22/19 Methadone doses evidenced a prepared-on date of 12/73/19 after the administration date (5 doses). Record review on 1/15/20 for Client #3 revealed: -Admitted on 4/13/18 with no identified diagnosis documented in the record. Review on 1/15/20 of Client #3's MAR from October 2019 through December 2019 revealed: -The 11/18/19 through 11/22/19 doses evidenced a prepared-on date of 12/27/19 after the administration date (5 doses). Record review on 1/15/20 for Client #4 revealed: -Admitted on 4/13/18 with diagnoses of Opioid Use Disorder, Hep C, Type II Diabetes, Morbid Obesity and Sleep Apnea. Review on 1/15/20 of Client #4's MAR from October 2019 through December 2019 revealed: -The 12/17/19 dose evidenced a prepared-on date of 1/7/20 after the administration date. Review on 1/15/20 of the record for Client #5 revealed: -Admitted 10/4/19 with no identified diagnosis	V 118	Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 29 documented in the record. Review on 1/15/20 of Client #5's MAR from October 2019 through December 2019 revealed: -The 11/15/19 through 11/17/19 Methadone doses evidenced a prepared-on date of 1/7/20 after the administration date (3 doses). -The 11/18/19 through 11/22/19 Methadone doses evidenced a prepared-on of 12/30/19 after the administration date (5 doses). Record review on 1/16/20 for Client #6 revealed: -Admitted on 2/16/18 with diagnosis of Chiari malformation. Review on 1/15/20 of Client #6's MAR from October 2019 through December 2019 revealed: - The 11/18/19 through 11/22/19 doses evidenced a prepared-on date of 12/30/19 after the administration date (5 doses). Record review on 1/16/20 for Client #7 revealed: -Admitted on 1/25/19 with no identified diagnosis documented in the record. Review on 1/15/20 of Client #7's MAR from October 2019 through December 2019 revealed: - The 11/18/19-11/22/19 doses evidenced a prepared-on date of 1/6/20 after the administration date. (5 doses). Record review on 1/16/20 for Client #8 revealed: -Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). Review on 1/15/20 of Client #8's MAR from October 2019 through December 2019 revealed: - The 11/19/19 through 11/22/19 evidenced a prepared-on date of 12/24/19 after the	V 118	Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 30 administration date (4 doses). - The 12/17/19 through 11/22/19 evidenced a prepared-on date of 1/7/20 after the administration date (1 dose). Review on 1/15/20 of the record for Client #9 revealed: -Admitted on 9/13/19 with a diagnosis of Opioid Use Disorder. Review on 1/15/20 of Client #9's MAR from October 2019 through December 2019 revealed: -The 11/18/19 through 11/20/19 Methadone doses evidenced a prepared-on date of 1/6/20 after the administration date (3 doses). -The 12/17/19 Methadone dose evidenced a prepared-on date of 1/6/20 after the administration date. Record review on 1/16/20 for Client #10 revealed: -Admitted on 8/11/17 with no identified diagnosis documented in the record. Review on 1/15/20 of Client #10's MAR from October 2019 through December 2019 revealed: -The 11/18/19 through 11/22/19 evidenced a prepared-on date of 1/6/20 after the administration date. (5 doses). Review on 1/15/20 of the record for Client #11 revealed: -Admitted on 3/1/19 with a diagnosis of Opioid Use Disorder. Review on 1/15/20 of Client #11's MAR from October 2019 through December 2019 revealed: -The 11/18/19 through 11/22/19 MAR documented the client missed daily doses of Methadone during this time frame. -Paper records kept by the LPN documented the	V 118	Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26 Ref. previous corrective action Pg.5 and 26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 31 client received the correct daily dose of 20 mg during this timeframe. Review on 1/16/20 of emails sent from the Director of Nursing Education/Compliance to the facility's LPN dated 1/13/20 and 1/14/20 revealed: -The LPN requested guidance on how to resolve a problem with the methadone inventory that resulted from the EMR being non-operational from November 15-17th, 2019. The methadone inventory was dispensed from the system but was not recorded in the EMR as having been dispensed. -The Director of Nursing Education/Compliance stated to the LPN that she was aware that data was missing from the system and she gave instruction on how to determine "who actually received medication on those days" by viewing the camera footage in the dispensary. -The LPN stated that a "missed dose report" from the EMR was utilized to determine who received medication, but the problem remained that the inventory had been deducted and the EMR didn't show that the methadone was dispensed to clients. -The Director of Nursing Education/Compliance stated that if the LPN "granted exceptions" in the EMR for missed doses and questioned if the LPN hooked up "an empty methadone bottle filled with water when granting exceptions?" -The LPN stated that granting exceptions in the EMR caused the inventory to be taken out twice, but the dosing log/MAR still reflected the clients did not get their medication and there was "no more inventory to finish correcting the missed days." Interview on 1/15/20 with the Licensed Practical Nurse (LPN) revealed: -The Electronic Medical Record (EMR) was not	V 118	Ref. previous corrective action Pg.26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 32 operational from approximately 11/14/16 through 12/5/19. Verbal orders given between these dates could not be documented until 12/5/19. No paper prescriptions were utilized in the interim. -The MARs were not accurate during the time the EMR was not operational. -The Prepared-on dates on the MAR were after the date the medication was administered because the LPN was advised by the Director of Nursing Education/Compliance to "pump water through the dispensing system to make inventory come out right at the end of the day." When water was run through the system, the computer recorded the water as Methadone being dispensed and then recorded a dose as prepared-on that date. -The reconciliation or inventory was not "evening out at the end of the day" and pumping water through the system was to show that a patient was there and to make the inventory come out right. This process caused "the documentation to look like a patient didn't get a dose when they did" or "it caused some patients to look like they were given a double dose." -Water was pumped through the Methadone system on 12/23/19 and 1/7/19 for doses administered 11/14/19 to 11/16/19 and 12/17/19 to 12/20/19. -No incident report was completed during this time to document the failure of the EMR and how staff responded to the situation. The only documentation of the incident with the EMR were emails to administration requesting guidance on what protocols to follow. -The LPN kept a paper dispensing log/MAR during the time the EMR was not in operation to document that clients received their medication dose. -The Information Technology (IT) department was to go back in and manually correct the MARs, but	V 118	Ref. previous corrective action Pg.5 and 26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 33 they did not do this. Interview on 1/16/20 with the Treatment Center Director (TCD) revealed: -When the computer system was not in operation, the nurses could not pull up the methadone dose in the system for each client. -The LPN used a print out of the daily dosing log from the day before the system stopped working to have documentation that showed the patients name and the milligrams of last dose administered. Additionally, clients were asked what their dose was and they initialed a document that they received their dose. -The physician was called and it was requested that he make no changes to client doses as the facility could not document physician orders without access to the EMR. -When the system came back on-line, efforts to correct the inventory (by running water through the system) caused the MAR to look like a client either double dosed or did not dose at all. -IT was supposed to manually correct the MAR, but they did not. Interview on 1/16/20 with the Facility's Information Technology (IT) representative revealed: -Confirmed there was a "system crash" in November through December 2019 due to ransomware and client data in the EMR was lost. -Was not aware of any requests to manually correct the MARs in the EMR but stated he had only worked there about 1.5 weeks. Review on 1/22/20 and 1/23/20 of Plan of Protection signed by the Regional Vice President (RVP) revealed: "V118- Medication Requirements: Access to the previous Electronic Medical Records (EMR) is being working at this time by the Corporate CIO	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 34 (Chief Information Officer) to allow access to those records by on site staff. The information will be accessible to the staff NLT [no later than] 1/23/2020. V118-Cont. the MD [medical director] orders will be given to the nurse to input into the system for the MD to sign. The nurse that receives the order is responsible for ensuring the MD signs them in the appropriate time frame. This will be the same nurse that completes the assesments prior to going to the MD for a decision. The MD will have a laptop allowing access to the EMR remotely as well. A report will be pulled by the nurse and verified by the TCD weekly to ensure that all orders are signed and being followed. This was discussed in training conducted on 1/22/2020 and will be covered again on 1/23/2020 with any staff that was not present on 1/22/20..." Refer to Tag V105 for the entire Plan of Protection. There was no overall system in place to prevent, identify and/or correct medication administration and documentation errors that occurred during and after the failure of the facility's Electronic Medical Record (EMR) in November -December 2019. The lack of an emergency protocol for a non-operational EMR caused client MARs to inaccurately reflect medication administration. The MARs were to be manually corrected by the Information Technology (IT) department when the EMR became operational again on November 17, 2019, but this had not been completed as of 1/16/20. All 11 clients reviewed evidenced errors and discrepancies on their November and December 2019 MARs. Due to the failure to accurately document medication administration it could not be determined if clients received their	V 118	Ref. previous corrective action Pg.5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 118	Continued From page 35 medications as ordered by the physician. When the EMR became non-operational, the Methadone inventory reconciliation process was also adversely impacted. The Methadone was dispensed to clients, but it was not recorded as having been dispensed in the EMR. When the EMR came back on-line, the system showed that the clients did not get any Methadone dispensed to them, but the Methadone inventory had been depleted at the end of the day. Efforts to correct the discrepancy between the amount of Methadone dispensed between 11/14/19 and 11/16/19 and what the EMR reported as dispensed (zero) caused the facility inventory to reflect a shortage in the Methadone inventory that has not been fully rectified. The facility attempted to "pump water through the system" to erroneously calculate that Methadone doses had been administered to clients when they had not been administered. In addition to the multiple issues that contributed to the failure of the EMR, there were missing physician orders for medication that had been administered (#1, #6) and orders to increase medication that were not implemented for 6 days for 1 client (#1). Also, orders to decrease take home doses were not implemented for 1 client (#11) after 3 separate physician orders specifically requesting action to be taken. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 131	Continued From page 36	V 131		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 1 of 3 audited staff (Counselor #3). The findings are: Record review on 1/16/20 for Counselor #3 revealed: - Hire Date: 4/23/19. - Registered with NCSAPPB (North Carolina Substance Abuse Professional Practice Board) as Certified Substance Abuse Counselor 9/26/19. - No HCPR prior to date of hire. Interview on 1/16/20 with the Treatment Center Director revealed: -She was not working at the program when Staff #1 was hired and did not know whether or not the HCPR was checked prior to hire date. This deficiency constitutes a recite deficiency and	V 131	Ref. previous corrective action Pg.3 Ref. previous corrective action Pg.3 Ref. previous corrective action Pg.3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 131	Continued From page 37 is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 131		
V 233	27G .3601 Outpt. Opiod Tx. - Scope 10A NCAC 27G .3601 SCOPE (a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. (b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual. (c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing doses for a period not to exceed 180 days. (d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 233		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 233	Continued From page 38 facility failed to provide coordination of care with medical providers for 4 of 11 audited clients (Clients #1, #5, #8 and #11). The findings are: Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with a diagnosis of Opioid Use Disorder. -Discharge Summary dated 4/3/19 from a previous methadone treatment program stated: "On the verge of relapse" and reported on the recent death of the client's wife. -Physician order dated 8/27/19 stated: "Needs Mental Health Referral." -There were no referrals to outside counseling agencies to coordinate care per physician order dated 8/27/19. -There were two counseling sessions documented for 2019 dated 5/10/19 (reported as 1st session) and 11/14/19. -Nurse Note dated 7/24/19 stated: "Pt. impaired, Pt. in clinic with son, both unable to sit still in their chairs, rapid movements, dry mouth, very talkative, pupils dilated. Rapid Urine Drug Screen positive for methamphetamines, Amphetamines, and Tetrahydrocannabinol (THC). Medical Doctor contacted by [former Treatment Center Director]. Nurse spoke with MD. New orders to no dose today." -No incident report or follow-up documentation to coordinate care following the 7/24/19 incident of client being impaired at the facility. Record review on 1/16/20 for Client #5 revealed: -Admitted on 10/4/19 with no identified diagnosis documented in the record. -Physician order dated 1/3/20 stated: "We need updated medication list recorded including baclofen pump and query with lab if baclofen will give false benzo positive. He may need more substance abuse counseling."	V 233	Ref. previous corrective action Pg.4 Training was conducted on 1/22/2020 and again on 2/12/2020 to ensure that the staff understood the procedures and protocols for a situation where the patient was deemed unfit to recieve dose. Ref. previous corrective action Pg.5	1/22/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 233	Continued From page 39 -Physician order dated 1/10/20 stated: "We need medication list and he may need more counseling." -No updated medication list was available as of 1/16/20 to evidence coordination of care with other prescribing physicians and/or additional counseling recommended in the 1/3/20 and 1/10/20 physician orders. Interview on 1/16/20 with Client #5 revealed: -UDS was positive for barbiturates. -Told staff that he had a Digi-pan pump for his bladder and that might cause the positive UDS for barbiturates as it relaxes muscles. -Signed a release of information and talked with the nurse and counselor. -Not sure if the facility called his physician on the Digi-pan pump. Record review on 1/16/20 for Client #8 revealed: -Admitted on 3/2/18 with a diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro Esophageal Reflux. -History of pain killer (pill and intramuscular) use since age 13. History of chronic pain. -Physician ordered EKG test on 5/29/19. -No documentation of coordination of care with the Primary Care Physician (PCP). Record review on 1/16/20 for Client #11 revealed: -Admitted on 3/1/19 with a diagnosis of Opioid Use Disorder. -UDS results identified 6 additional, consecutive dates as positive for Benzodiazepines: 10/21/19, 10/28/19, 11/25/19, 12/9/19, 12/23/19, and 1/8/20. -There were no Release of Information (ROI) documents in the clients record. -Physician order dated 10/10/19 stated: "Who is she seeing for mental health for RX for Valium?	V 233	The Medication list is part of the admission process, pulled by the admission nurse and be maintained in the patient chart. This can also be updated periodically per the Physician's order. The Clinical staff will also encourage the patient to present any and all medications and they will document any medications in the patient file. The Clinical staff will also notify the Medical Staff of any new or renewed medications. This was reviewed on 1/23/2020 and again on 2/12/2020. Ref. previous corrective action Pg.4 Ref. previous corrective action Pg.4 Training was conducted on 1/23/2020 and reviewed again on 2/12/2020 as to the ROI procedures, who is responsible and where the documentation is located to ensure completion and verification	2/12/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 233	Continued From page 40 Need ROI done to make sure aware of buprenorphine and Valium interaction." -Physician order dated 10/12/19 stated: "Need ROI for RX for Benzos to have ended on 10/12/19-is she taking PRN for stress? Does she need to talk to a counselor more for mental health?" -General note written by the Treatment Center Director and dated 11/5/19 stated: "Patient has illicit UDS for Benzos and RX has expired." -Counseling note dated 12/3/19 stated: "RX has not been verified and need an ROI for verification." Client stated her new prescription was is in the car. Note ends by stating medical has been given updated prescription information. There was no written update regarding if an ROI was signed on this date per physician orders dated 10/11/19 and 10/12/19. -Physicians Order dated 1/8/20 reports "Pt. has brought in current RX for all medication including the Benzo Rx." Interview on 1/16/20 with Client #11 revealed: -"Not sure" if coordination of care occurred between the facility and the physicians prescribing psychotropic medications (Valium and Wellbutrin). -"The computer shut down and that effected things. Once I had a hold put on my next dose because they had not entered my med. count and proof of prescription for my Valium into the computer because the computer wasn't working." Interview on 1/16/20 with the Licensed Practical Nurse (LPN) regarding Client #11's physician orders for a Release of Information (ROI) revealed: -There was no designated person to ensure physician orders get followed. Anyone can read the orders and follow them, to include counselors,	V 233	A Training was conducted on 2/12/2020 that detailed the ROI process and how that process works with the Continuum of Care procedures previously discussed. Ref. previous correction and manual processes are in place as a secondary meausre to ensure the proper documentation is always completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 233	Continued From page 41 RNs, and LPNs. -"Can't find an ROI. It could be in the box of documents not scanned yet." Interview on 1/15/20 with Counselor #3 revealed: -Coordination of care was not clearly defined. Didn't know who was responsible for what or for adding information into the system. It was hit or miss as to who followed up on doctor's orders for things such as EKGs. Interview on 1/16/20 with the LPN (Licensed Practical Nurse) revealed: -She was lead nurse and "had worked at the facility since 8/30/18. -The company "switched EMR (electronic medical record) systems on 6/18/19. Only the most recent orders were imported as well as UDS (urine drug screens)- there was no medical, no labs (bloodwork), no original orders, no h and p's (history and physicals), no assessments and no treatment plans. I realized the first of July we couldn't get previous work so I called [previous EMR system] myself but they never returned the call. I told [the former Treatment Center Director (TCD)] as well as [the Regional Director] in Texas -both said they would look into it but nothing ever happened." Interview on 1/16/20 with the Treatment Center Director (TCD) revealed: -Many of the documents needed were in the old system and could not be pulled forward. -"Could not find any evidence that a referral for EKG had been made [for Client #8]." - System crashed 11/15/19 due to malware in the corporate server but clinic was not fully back up until 1/15/20. Unable to keep up with client care and electronic research. -"We are a small clinic-concerns are verbally	V 233	Ref. previous corrective action Pg.40 Ref. previous corrective action Pg.4 Ref. previous corrective action Pg.5 Ref. previous corrective action Pg.5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 233	Continued From page 42 shared." -Recently began staffing clients at Friday staff meeting when the Doctor can also attend. -"To our knowledge nothing detrimental has occurred." This deficiency is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 233		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB.	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 235	Continued From page 43 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all staff received continuing education to include understanding of the nature of addition, withdrawal syndrome, group and family therapy and infectious diseases for 2 of 3 audited staff (Treatment Center Director (TCD) and Counselor #3). The findings are: Record review on 1/16/20 for Counselor #3 revealed: -Date of Hire: 4/23/19 -No documentation of current training on individual and group therapy and withdrawal syndrome. Record review on 1/16/20 for TCD revealed: -Date of Hire: 8/19/18 -No documentation of current training on withdrawal syndrome. Interview on 1/15/20 with Counselor #3 revealed: -Some training is completed on line but there she was not aware of specific requirements for training. Interview on 1/16/20 with TCD revealed: -Trainings were on line and could be accessed anytime. -She was not aware of all the required trainings. This deficiency constitutes a recite deficiency and is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 235	ref previous corrections with the addition of required training to the Relias system. Ref. previous corrective action Pg.4 Ref. previous corrective action Pg.4 Ref. previous corrective action Pg.4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 44	V 238		
V 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. (1) Levels of Eligibility are subject to the following conditions: (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic; (B) Level 2. After a minimum of 90 days of	V 238		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 45	V 238		

continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week;
(C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week;
(D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five take-home doses and shall ingest all other doses under supervision at the clinic each week;
(E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week;
(F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and
(G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month.
(2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility:
(A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 46 A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility by one level of eligibility; (B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and (C) The reinstatement of take-home eligibility shall be determined by each Outpatient Opioid Treatment Program. (3) Exceptions to Take-Home Eligibility: (A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous treatment. (B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall make monthly clinic visits. (4) Take-Home Dosages For Holidays: Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following: (A) An additional one-day supply of	V 238		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 47 methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday. (B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above. (g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter. (h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method. (i) Client Discharge Restrictions. No client shall be discharged from the facility while physically dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug. (j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities	V 238		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 48 which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for bottle checks, bottle returns or solid dosage form call-in's; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction; (5) client attendance minimums; and (6) procedures to ensure that clients properly ingest medication.	V 238		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 49 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that during the first year of continuous treatment each client attended a minimum of two counseling sessions per month, and after the first year of treatment attended at least one counseling session per month for 5 of 11 audited clients (Clients #1, #2, #6, #7, #11); failed to conduct a minimum of one random urine drug screen (UDS) each month for 2 of 11 audited clients (Clients #8, #10); failed to ensure that one drug test per 3 month period was observed for 9 of 11 audited clients (Clients #1, #2, #3, #4, #5, #7, #8, #10, #11) and failed to ensure 9 of 11 audited clients (Clients #1, #2, #3, #5, #6, #7, #8, #10 and #11) were not dually enrolled within a 75 miles radius. The findings are: Finding #1: Facility failed to ensure counseling sessions as required. Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -Counseling bimonthly sessions not provided for October 2019, November 2019 (1 session) December 2019. Record review on 1/15/20 for Client #2 revealed: - Admitted on 9/22/17 with diagnosis of Opioid Use Disorder. -Counseling sessions not provided for November 2019 or December 2019. Record review on 1/16/20 for Client #6 revealed: - Admitted on 2/16/18 with diagnosis of Chiari malformation.	V 238	A clinical report is printed mid-month in order to manually track and ensure that every patient recieves the correct number of clinical sessions. Each clinician keeps a monthly record of their sessions in regards to their caseload. The EMR also tracks the clinical sessions allowing for additional oversight to ensure the sessions are completed. Chart audits will also be conducted by the TCD and Clinical Director. Ref. corrective action above Ref. corrective action above	1/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 50 -Counseling sessions not provided for August 2019 or September 2019. Record review on 1/16/20 for Client #7 revealed: - Admitted on 1/25/19 with no identified diagnosis documented in the record. -Counseling sessions not provided for October 2019. Record review on 1/16/20 for Client #11 revealed: - Admitted on 3/1/19 with diagnosis of Opioid Use Disorder -Counseling bimonthly sessions not provided for November 2019 and only 1 session for October 2019 and 1 session for December 2019 Finding #2: Facility failed to ensure UDS monthly. Record review on 1/16/20 for Client #8 revealed: - Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). -UDS not provided for November 2019. Record review on 1/16/20 for Client #10 revealed: - Admitted on 8/11/17 with no identified diagnosis documented in the record. -UDS not provided for October 2019. Finding #3: Facility failed to ensure UDS were observed quarterly. Record review on 1/15/20 for Client #1 revealed: -Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -Observed UDS not provided for male client since May 2019. Record review on 1/15/20 for Client #2 revealed:	V 238	Ref. corrective action pg. 50 Ref. corrective action pg. 50 Ref. corrective action pg. 50 Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 51 - Admitted on 9/22/17 with diagnosis of Opioid Use Disorder. -Observed UDS not provided for male client since May 2019. Record review on 1/15/20 for Client #3 revealed: - Admitted on 4/13/18 with no identified diagnosis documented in the record. -Observed UDS not provided for male client since May 2019. Record review on 1/15/20 for Client #4 revealed: - Admitted on 4/13/18 with diagnoses of Opioid Use Disorder, Hep C, Type II Diabetes, Morbid Obesity and Sleep Apnea. -Observed UDS not provided for male client since May 2019. Record review on 1/16/20 for Client #5 revealed: - Admitted on 10/4/19 with no identified diagnosis documented in the record. -Observed UDS not provided for Male client since May 2019. Record review on 1/16/20 for Client #7 revealed: - Admitted on 1/25/19 with no identified diagnosis documented in the record. - Observed UDS not provided for male client since May 2019. Record review on 1/16/20 for Client #8 revealed: - Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). - Observed UDS not provided for male client since May 2019. Record review on 1/16/20 for Client #10 revealed: - Admitted on 8/11/17 with no identified diagnosis	V 238	Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 52 documented in the record. -Observed UDS not provided for male client since May 2019.	V 238	Ref. corrective action pg. 4	
	Record review on 1/16/20 for Client #11 revealed: - Admitted on 3/1/19 with diagnosis of Opioid Use Disorder -Quarterly observed UDS not provided for female client between 8/21/2019 and 1/8/20 based on counselor note 1/8/20.		Ref. corrective action pg. 4	
	Finding #4: Facility failed ensure non-dual enrollment. Record review on 1/15/20 for Client #1 revealed: - Admitted on 3/20/19 with diagnosis of Opioid Use Disorder. -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment.		Ref. corrective action pg. 4	
	Record review on 1/15/20 for Client #2 revealed: - Admitted on 9/22/17 with diagnosis of Opioid Use Disorder. -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment.		Ref. corrective action pg. 4	
	Record review on 1/15/20 for Client #3 revealed: - Admitted on 4/13/18 with no identified diagnosis documented in the record. -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment.		Ref. corrective action pg. 4	
	Record review on 1/16/20 for Client #5 revealed: - Admitted on 10/4/19 with no identified diagnosis documented in the record. -No evidence of form faxed to local facilities, nor state integrated system checked to determine		Ref. corrective action pg. 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 53 possible dual enrollment. Record review on 1/16/20 for Client #6 revealed: - Admitted on 2/16/18 with diagnosis of Chiari malformation. -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment. Record review on 1/16/20 for Client #7 revealed: - Admitted on 1/25/19 with no identified diagnosis documented in the record. -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment. Record review on 1/16/20 for Client #8 revealed: - Admitted on 3/2/18 with diagnoses of Opioid Dependence, Depression, Anxiety, Morbid Obesity and Gastro-Esophageal Reflux Disorder (GERD). -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment. Record review on 1/16/20 for Client #10 revealed: - Admitted on 8/11/17 with no identified diagnosis documented in the record. -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment. Record review on 1/16/20 for Client #11 revealed: - Admitted on 3/1/19 with diagnosis of Opioid Use Disorder -No evidence of form faxed to local facilities, nor state integrated system checked to determine possible dual enrollment. Interview on 1/16/20 with Counselor #2 revealed:	V 238	Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 54 -Central registry checks were not done due to "being unorganized and overwhelmed." -"A previous receptionist did them and uploaded into the system but she quit without a notice." -"There was no identified staff person assigned to complete these." Interview on 1/15/20 with Counselor #3 revealed: -Never had a formal procedure for intakes-no checklist or process to complete an intake. Whoever was assigned to intakes for the day took on that client on their caseload. -"There were times we could not fulfill counseling requirements because we had to cover the front desk duties." -There was no formal procedure of reviewing UDS. -Now a COWS assessment was required when a client requested an increase. This is a new requirement. Nurses had to complete the COWS. -Former Treatment Center Director (TCD) expected counselors to request dose or level increases. Now counselors complete a paper copy of request with client report of symptoms and then goes to nursing. Interview on 1/16/20 with the TCD revealed: -The dual enrollment consents were in the intake packets and was the responsibility of the intake staff to fax new client enrollment to local clinics or check the state integrated "Lighthouse" system. -Counselors rotated intake responsibilities. -Intakes were only done on Fridays when the doctor was there. -She was not aware dual enrollments were not being checked. There were bigger systems issues that needed correction. This deficiency is cross referenced into 10A	V 238	Ref. corrective action pg. 4 Additional staff was hired to ensure that the clinical staff were not tasked with additional duties ensuring that they had time to complete requirements. Ref. corrective action pg. 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 238	Continued From page 55 NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 238		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 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.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 536	Continued From page 56 (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 any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 536	Continued From page 57 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. (1) Documentation shall include:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 536	Continued From page 58 (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on personnel record review and staff interviews, the facility failed to ensure that staff completed training in alternatives to restrictive intervention prior to providing services for 3 of 3 audited staff (Treatment Center Director (TCD), Licensed Practical Nurse (LPN) and Counselor #3). The findings are: Record review on 1/16/20 for LPN revealed: -Date of Hire: 8/30/18 -No documentation of current training in alternatives to restrictive interventions. Record review on 1/16/20 for Counselor #3 revealed: -Date of Hire: 4/23/19	V 536	Ref. corrective action pg. 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDMARK TREATMENT CENTERS MURPHY	7540 US HIGHWAY 64 BRASSTOWN, NC 28902

(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 536	Continued From page 59 -No documentation of current training in alternatives to restrictive interventions. Record review on 1/16/20 for TCD revealed: -Date of Hire: 8/19/18 -No documentation of current training in alternatives to restrictive interventions. Interview on 1/16/20 with the TCD revealed: -She started at the facility October 1, 2019. She had previously owned the clinic but sold to the current licensee. She worked for the Licensee in another facility before returning to the clinic. -She was not aware staff did not have all of the required trainings. This deficiency constitutes a recite deficiency and is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 violation and must be corrected within 23 days.	V 536	Ref. corrective action pg. 4 Ref. corrective action pg. 4 Ref. corrective action pg. 4	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

February 7, 2020

Wade Reed, Regional Vice President
BayMark Health Services of North Carolina, Inc.
1720 Lakepointe Dr, Ste. 117
Lewisville, TX 75057

Re: Annual and Follow up Survey completed January 23, 2020
Medmark Treatment Centers Murphy, 7540 US Highway 64, Brasstown, NC 28902
MHL # 022-017
E-mail Address: WReed@baymark.com

Dear Mr. Reed:
Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 1/23/20. Deficiencies were cited.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violations are cited for:
  - 10A NCAC 27G .0209 Medication Requirements (V118)
  - 10A 27G .0201 Governing Body Policies (V105) with cross references:
    - 10A NCAC 27G .0201 Governing Body Policies (V105)
    - 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110)
    - 10A NCAC 27G .0205 (a-b) Assessment and Treatment/Habilitation or Service Plan (V111)
    - 10A NCAC 27G .0205 (c-d) Assessment and Treatment/Habilitation or Service Plan (V112)
    - N.C.G.S. 131E-256 Health Care Personnel Registry (V131)
    - 10A NCAC 27G .3601 Scope (V233)
    - 10A NCAC 27G .3603 Staff (V235)
    - 10A NCAC 27G .3604 Outpatient Opioid Treatment Operations (V238)
    - 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536)

Time Frames for Compliance

- Type A1 violations and all cross referenced citations must be ***corrected*** within 23 days from the exit date of the survey, which is 2/15/20. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred)

against BayMark Health Services of North Carolina, Inc. for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Sonia Eldridge, Mountains Team Leader at 828-665-9911.

Sincerely,

Cathy Samford

Cathy Samford
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov,
DMH/DD/SAS
dhhs@vayahealth.com
Smith Worth, SOTA Director
Pam Pridgen, Administrative Assistant