Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		D.C.
		MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E. ZIP CODE	
		7540 US	HIGHWAY 64	,	
MEDMAR	K TREATMENT CENTER	S MURPHY BRASST	OWN, NC 28902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on 10/28/20. The cor (Intake #NC0016150) Current census in this This facility is license	plaint survey was completed implaint was substantiated D). Deficiencies were cited. is 3600 program was 87. In the following service 27G.3600 Outpatient Opioid			
V 105	27G .0201 (A) (1-7) (	Governing Body Policies	V 105		
	POLICIES  (a) The governing bor facility or service shall written policies for the (1) delegation of man operation of the faciliti (2) criteria for admiss (3) criteria for dischar (4) admission assess (A) who will perform to (B) time frames for co (5) client record mana (A) persons authorized (B) transporting record (C) safeguard of record defacement or use by (D) assurance of cond (E) assurance of cond (E) screenings, which (A) an assessment of problem or need; (B) an assessment of	agement authority for the cy and services; ion; ge; ments, including: he assessment; and appleting assessment. agement, including: ed to document; ds; rds against loss, tampering, a unauthorized persons; and accessibility to ll times; and fidentiality of records. shall include: the individual's presenting to address the individual's			

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

TITLE (X6) DATE

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILANC	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT LETED	
		MHL022-017	B. WING		R-C <b>10/28/2020</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
MEDMARI	TREATMENT CENTER	S MURPHY	HIGHWAY 64 OWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	E
V 105	activities, including:  (A) composition and a assurance and quality (B) written quality assimprovement plan;  (C) methods for moniquality and appropriatincluding delineation utilization of services  (D) professional or cliar requirement that stapprofessionals and proshall be supervised by that area of service;  (E) strategies for imperiment (F) review of staff quadetermination made to treatment/habilitation  (G) review of all fatality were being served in residential programs  (H) adoption of standand programmatic periments a level of competence to the prevented of the prevente	and quality improvement activities of a quality y improvement committee; surance and quality toring and evaluating the teness of client care, of client outcomes and inical supervision, including aff who are not qualified ovide direct client services by a qualified professional in roving client care; alifications and a to grant privileges: ties of active clients who area-operated or contracted at the time of death; ards that assure operational erformance meeting of practice. For this standards of practice" upetence established with ailing and accepted gree of knowledge, skill and her practitioners in the field;	V 105			
	This Rule is not met	as evidenced by:				

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Division of Health Service Regulation

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2.1.2.1.0.00		.52.11.10,11.01.110.11.10.152.1.1	A. BUILDING: _		<del></del>		
		MHL022-017	B. WING		I	-C <b>28/2020</b>	
NAME OF PROVI	DER OR SUPPLIER	STREE	ADDRESS, CITY, STA	TE, ZIP CODE			
MEDMARK TR	REATMENT CENTERS	SMURPHY	IS HIGHWAY 64 STOWN, NC 28902	2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
Bai gov add pro sta Cro Ass See inte trea agr effe and pro und 2/7 (CI not fac effe clie #17 Cro (V2 the witt (CI dos em (CI	verning body failed option of standards orgrammatic performandards of practice.  oss Reference: 10 A sessment and Treastruce Plan (V112). erviews the facility fatment plans including the ecting 3 of 9 audited disposed to a new clie detailed to provided in the foreility was under a subjective 2/7/20, effections (GD #10, #11, 47 and #18).  Oss Reference: 10 A 233). Based on receive a subjective detailed to provide the effective to the provided to provide the effective that the effective	ews and interviews, the to develop and implement that assure operational and nance meeting applicable. The findings are:  NCAC 27G .0205(c) tment/Habilitation or Based on record review and failed to ensure the led the written consent or not or responsible party dictional clients (Clients #6, #8, are treatment was not not when the facility was find admissions effective. In newly admitted client to ensure treatment was most guest dosing while the aspension of admissions ting 9 of 9 guest dose (GD) #12, #13, #14, #15, #16,  NCAC 27G .3601 Scope for reviews and interviews, evide coordination of care as for 3 of 9 audited clients (P); and failed to ensure or clients when an citing 8 of 9 audited clients (P); and failed to ensure or clients when an and the coordination of care as for 3 of 9 audited clients (P); and failed to ensure or clients when an and the coordination of care or clients when an and the coordination of care as for 3 of 9 audited clients (P); and failed to ensure or clients when an and the coordination of care or clients when an and the coordination or care	V 105				

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		LETED		
		MHL022-017	B. WING		I	R-C <b>28/2020</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
MEDMAR	K TREATMENT CENTER	S MURPHY 7540 US	6 HIGHWAY 64				
III DIII AN	TREATMENT SERVER	BRASS	TOWN, NC 28902	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 105	Continued From page	e 3	V 105				
	Cross Reference: 10.6 Compliance with Stat (V237). Based on rec the facility failed to er	A NCAC 27G .3604 te Authority Regulations cord reviews and interviews					
	Based on record revir facility failed to ensur continuous treatment minimum of two coun and after the first yea least one counseling audited clients (Clien- failed to conduct a midrug screen (UDS) ea clients (Client #2); an audited clients (Client	A NCAC 27G .3604 eatment Operations (V238). ews and interviews, the e that during the first year of each client attended a iseling sessions per month ir of treatment attended at session per month for 6 of 9 its #3, #5, #6, #7, #8 and #9); inimum of one random urine each month for 1 of 9 audited d failed to ensure 3 of 9 its #1, #5 and #6) were not a 75 miles radius. The					
	Protection dated 10/2 Treatment Center Dir	and 10/28/20 of the Plan of 28/20 and signed by the ector (TCD) revealed:					
		ion will the facility take to he consumers in your care?					
	V105/V112						
	Treatment Plan due of daily basis through the medical record system [Electronic medical record clectronic health record content of the medical record conten	rector ("TCD") will monitor dates and signatures on a se facility's new [electronic m] and signature alert page. ecord system] is the facility's ord system.					
		rior to the hire of the current					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	MHL022-017 B. WING		<b>I</b>	R-C <b>/28/2020</b>		
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MUDDHY 7540	US HIGHWAY 64			
WILDWAN	K IKLAIMEN CENTEN	BRA	SSTOWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 105	Continued From page	e 4	V 105			
V 105	TCD at the facility. Naccepted other than are currently being ar referring all admissio [Opioid Treatment Pr Based Opioid Treatment that the facility can rethat the facility was previsuspension of Admis prohibition of treating who are not admitted of October 27, 2020, calls concerning Gue assist in providing the information regarding Arrangements have to guest doser to receiv clinic. As of October guest dosing with this one patient that was October 23, 2020 whith the provided that was October 23, 2020 whith the patient 24, 2020 whith the patient 24, 2020 whith the patient 24, 20	o new admissions were the one admission, and none occepted. The facility is n inquiries to other OTP's ograms] or OBOT's [Office nent]. The facility will a until notified by the state esume admissions.  I ously not aware that the asions order also included a guest dosing individuals as patients of the facility. As the facility will now direct all est Dosing to the TCD to be home clinic with				
	Results of the EKG of documented in the pareviewed this with the 10/27/2020 and docufiles.  The facility also now	or a patient's refusal will be				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  V 105  Continued From page 5  nurse is located in Blairsville, Georgia, [Nurse's name] was hired March 26, 2020 and obtained her multi state LPN (Licensed Practical Nurse) license August 20, 2019. [Nurse] agreed to assist at this facility if needed upon hire. Three nurses from the Durham clinic have agreed as of October 28, 2020 to assist with coverage at this facility should the need arise: [three Nurses' name, license numbers and expiration dates]. Agreements were made with the [name of clinic in Georgia] and the [name of clinics in North Carolina] should the Blairsville, Georgia clinic be unable to accommodate the facility's clinic patients.  V235  Each staff member is assigned upon hire and	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
MEDMARK TREATMENT CENTERS MURPHY   T540 US HIGHWAY 64 BRASSTOWN, NC 28902			MHL022-017	B. WING		l l	-
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY   DEFICIENCY    V 105   Continued From page 5   Nurse is located in Blairsville, Georgia, [Nurse's name] was hired March 26, 2020 and obtained her multi state LPN (Licensed Practical Nurse)   license August 20, 2019. [Nurse] agreed to assist at this facility if needed upon hire. Three nurses from the Durham clinic have agreed as of October 28, 2020 to assist with coverage at this facility should the need arise: [three Nurses' name, license numbers and expiration dates]. Agreements were made with the [name of clinic in Georgia] and the [name of clinics in North Carolina] should the Blairsville, Georgia clinic be unable to accommodate the facility's clinic patients.   V235    Each staff member is assigned upon hire and	NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	E, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 105  Continued From page 5  nurse is located in Blairsville, Georgia, [Nurse's name] was hired March 26, 2020 and obtained her multi state LPN (Licensed Practical Nurse) license August 20, 2019. [Nurse] agreed to assist at this facility if needed upon hire. Three nurses from the Durham clinic have agreed as of October 28, 2020 to assist with coverage at this facility should the need arise: [three Nurses' name, license numbers and expiration dates]. Agreements were made with the [name of clinic in Georgia] and the [name of clinics in North Carolina] should the Blairsville, Georgia clinic be unable to accommodate the facility's clinic patients.  V235  Each staff member is assigned upon hire and	MEDMAR	K TREATMENT CENTER	S MURPHY				
nurse is located in Blairsville, Georgia, [Nurse's name] was hired March 26, 2020 and obtained her multi state LPN (Licensed Practical Nurse) license August 20, 2019. [Nurse] agreed to assist at this facility if needed upon hire. Three nurses from the Durham clinic have agreed as of October 28, 2020 to assist with coverage at this facility should the need arise: [three Nurses' name, license numbers and expiration dates]. Agreements were made with the [name of clinic in Georgia] and the [name of clinics in North Carolina] should the Blairsville, Georgia clinic be unable to accommodate the facility's clinic patients.  V235  Each staff member is assigned upon hire and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
annually thereafter the trainings: Learning to Love Group, which meets the states requirements for group therapy training; Assessing Opioid Abuse in Families, which meets the state's requirement for family therapy training; and Harm Reduction and/or Medication Assisted Treatment for Opioid Addiction, both course meet requirements for withdrawal syndrome training. All current staff have completed these trainings. Training completion is monitored by the TCD monthly.  [TCD]- Assessing Opioid Abuse in Families completed 07/23/2020 - Family Learning to Love Groups completed 07/27/2020 - Group Medication-Assisted Treatment for Opioid Addiction completed 07/23/2020 - withdrawal syndrome  [Counselor #3] Assessing Opioid Abuse in	V 105	nurse is located in Bla name] was hired Man her multi state LPN (L license August 20, 20 at this facility if neede from the Durham clini October 28, 2020 to a facility should the nee name, license numbe Agreements were ma in Georgia] and the [r Carolina] should the B unable to accommoda patients.  V235  Each staff member is annually thereafter th Love Group, which m requirements for grou Assessing Opioid Abu the state's requiremen and Harm Reduction Treatment for Opioid requirements for with All current staff have Training completion is monthly.  [TCD]- Assessing Op completed 07/23/202 Learning to L 07/27/2020 - Group Medication-A Addiction completed 0 syndrome	airsville, Georgia, [Nurse's ch 26, 2020 and obtained Licensed Practical Nurse) and provided the provided to assist and upon hire. Three nurses ic have agreed as of assist with coverage at this ad arise: [three Nurses' ars and expiration dates]. In the provided with the [name of clinic name of clinics in North and a clinic harmonic of the provided the provided the provided to the provided the	V 105			

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		MHL022-017	B. WING			R-C // <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, STATE	E, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY 754	0 US HIGHWAY 64			
MEDMAK	K IKEAIWENT OENTER	BRA	ASSTOWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 105	Continued From page	e 6	V 105			
	09/11/2020 - Family					
	Assessing Opioid Abi 02/18/2020 - Family		rning			
		oleted 02/27/2020 - Group				
	V237					
	In the future, the TCD will contact the SOTA's [State Opioid Treatment Authority] office, as well as utilize the Central Registry in case of emergency impacting the ability to dose patients within a hour.					
	V238					
	the facility's Complian facilitates a discussion meeting regarding the	ecord system] reports and				
	07/14/2020 which is a the TCD at the end of the order suspending The TCD will review within 1 business day documentation and reincluding dual enrolln					
		st of all patients who need 2x g by 11/7/2020. TCD will	(			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL022-017	B. WING			R-C 0/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	S HIGHWAY 64 STOWN, NC 28902			
0/A) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 105	Continued From page	e 7	V 105			
	patients on this list, w medical record systel counseling. Counseld ensure that all patien requirement.  UDS will be obtained Any discrepancies wi	ors will review the list daily to				
	patient's record.  TCD will print a monthly patient roster with UDS dates. TCD will monitor the list on a daily basis, checking off patients who have met the required UDS for the month. On the 20th of each month, if any patient missed prior to the 20th, TCD/Counselors will flag the patient to submit a UDS on their next visit to the clinic. This list will be monitored daily.					
	V118					
	order section of [elect system], the doctor worders if needed. The alerts daily to insure exceptions, have been unsigned at the end contact the doctor to orders will be signed hours. TCD/Nursing voices	vill be contacted for verbal e TCD will review medical doctor's orders, including en signed. If orders are of the day the TCD will sign the order. All verbal by the physician within 72 will monitor exceptions on a ill be contacted whenever an				
	Describe your plans thappens.	to make sure the above				
	The facility's Regiona	al OTP Compliance Manager				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		MHL022-017	B. WING			R-C <b>)/28/2020</b>
NAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	TOWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 105	will continue to perfor for compliance. The facility's counseled patient records week least 10 peer reviews. Program, counselors internal charts by 11/include treatment plad patients need clinical. The facility's [electron Compliance Dashboas implemented in September Staff to monitor Treatment of the facility's performed in September Staff to monitor Treatments in the facility of the survey and Physical monitoring the Compliance counseling, current and History and Physical monitoring the Compliance implementation.  TCD will review assign Love Groups and Assign additional requirements by 11/0 are needed, all staff with them by 11/15/2020. This facility served 87 the survey with a prinder Dependence. The facility served guest a suspension of admit Clients received guest days to a maximum of the facility served gues	ors will each audit at least 2 by. The TCD will perform at a on patient records monthly.  and TCD, will audit all all all all all all all all all al	V 105			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		MHL022-017 B. WING 10/28/20		10/28/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
		7540 US H	IGHWAY 64			
MEDMARI	K TREATMENT CENTERS	S MURPHY BRASSTO	WN, NC 28902	!		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 105	Continued From page	9	V 105			
V 100	arose at the facility the nurse to dose clients. plan for clients to recensear-by sister clinic we executed. It was unable many of the 111 clienter facility at the time the arose went without the days. Treatment plantinclude the client's sign be determined if the correctment plan. Coorproviders for an EKG 4 months after the phore of clients. Nine clients were not check dually enrolled in anough a 75-mile radius priority failed to complete the continuing education.  This deficiency constitute Type A1 rule violates serious neglect. An acceptance of the continuing education.	at left the facility without a The attempted emergency eive their medication at a ras not successfully ble to be determined how the who were active with the eneed for emergency dosing eir medication for three is were not complete to gnature for 3. It was able to elient was involved with their dination of care with medical was not completed until 3 to ysician's order was written ents failed to receive the two over month for 3 to 6 months. Ceive monthly UDS and 9 ked to ensure they were not ther treatment facility within to admission. Three staff required Family Therapy	V 103			
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible pe	ASSESSMENT AND TATION OR SERVICE  developed based on the artnership with the client or erson or both, within 30 days ts who are expected to				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE	
701012701	or connection	IBERTIN ISTATION NOMBER.	A. BUILDING: _			
		MHL022-017	B. WING		<b>I</b>	-C <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	S HIGHWAY 64 TOWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 112	receive services beyon (d) The plan shall into (1) client outcome(s) achieved by provision projected date of ach (2) strategies; (3) staff responsible (4) a schedule for reannually in consultation responsible person on (5) basis for evaluation outcome achievement (6) written consent of responsible party, or	ond 30 days. clude: ) that are anticipated to be nof the service and a ievement; ; eview of the plan at least on with the client or legally r both; ion or assessment of	V 112			
	facility failed to ensurincluded the written of client or responsible clients (Clients #6, #8 treatment was not prothe facility was under effective 2/7/20, effective (Client #5); and was not provided in the while the facility was admissions effective	ews and interviews the e the treatment plans onsent or agreement by the party effecting 3 of 9 audited 3, and #9); failed to ensure ovided to a new client when a suspension of admissions sting 1 of 1 newly admitted if ailed to ensure treatment the form of guest dosing under a suspension of 2/7/20, effecting 9 of 9 guest D #10, #11, #12, #13, #14,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
A. BUILDING:			COMP	LETED		
		MHL022-017	B. WING	B. WING		-C <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	ATE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	US HIGHWAY 64 SSTOWN, NC 28902	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 112	Continued From page	e 11	V 112			
	-admission date 2/7/2 -diagnoses of Hepatit Dependencetreatment plan dated 9/3/20 (after surveyor Review on 9/24/20 of -admission date 1/3/2 -diagnoses of Chronic Opioid Dependencetreatment plan dated the client.  Review on 9/24/20 of -admission date 1/17, -diagnoses of Diabete Dependence.	is C and Opioid I 2/7/20 was not signed until rinquiry). Client #8's record revealed: O. C Neuropathy Pain and I 1/13/20 was not signed by Client #9's record revealed:				
	Interviews were atten 10/12/20. No calls we					
	Director (TCD) revealushed rev	with the Treatment Center led: nd the above treatment for Clients #6, #8 and #9.				
	Finding #2:					
	-admission date 4/28, -diagnoses of Bipolar Dependence.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		D.C
		MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF D	ROVIDER OR SUPPLIER	CTDEET A	DDRESS, CITY, STA	TE ZID CODE	,
NAME OF P	ROVIDER OR SUPPLIER		HIGHWAY 64	TE, ZIF GODE	
MEDMAR	K TREATMENT CENTER	SMURPHY	TOWN, NC 28902		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETE
V 112	Continued From page	<del>:</del> 12	V 112		
		ration Record (MAR) on was dosed 30 milligrams			
	-he started treatment facility could not acce	nsfer" in May when he			
	the facility was under -the Former TCD and of Operations approve -since he had been in guest dosing they we	ith the TCD revealed: 0 on 7/6/20 and was aware suspension of admissions. Former Regional Director ed Client #5's admission. treatment for a month and admitted him. admitted for guest dosing			
	Finding #3:				
	Review on 9/2/20 of the facility's current census revealed: -a total of 89 clients"Guest-Methadone" was next to two names.				
	9/2/20 revealed: -there were a total of after a suspension of 2/7/20.	Discharges from 2/17/20 - 9 clients who guest dosed admission was issued on			
	-GD #10 - dosed 2 da -GD #11 - dosed 27 d -GD #12 - dosed 127 -GD #13 - dosed 12 d -GD #14 - dosed 14 d -GD #15 - dosed 8 da -GD #16 - dosed 24 d -GD #17 - dosed 4 da	ays. days. lays. lays. lys. lays.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL022-017	B. WING		R-C 10/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE	
MEDMAR	K TREATMENT CENTER	S MURPHY 7540 L	JS HIGHWAY 64		
MEDINAR	THEATMENT SERVER	BRAS	STOWN, NC 28902	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
V 112	12 Continued From page 13		V 112		
	-GD #18 - dosed 8 days.				
V/ 440	Interview on 9/24/20 -the two names on the discharge list were clithey received no other than their dose of methey did not count the and did not see this a suspension of admission This deficiency is cross NCAC 27G .0201 Go (V105) for failure to civilation.	with the TCD revealed: e 9/2/20 census list and the ients who guest dosed. er services at the clinic other thadone. em as actual admissions as a violation of their sions. ss referenced into 10 A everning Body Policies orrect a Type A1 rule	V/440		
V 118	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons transfer or other leprivileged to prepare  (4) A Medication Admall drugs administered current. Medications	9 MEDICATION istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The	V 118		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		MHL022-017	B. WING		10/28/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	IIGHWAY 64 DWN, NC 28902	,		
0(1) 15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECTION	NI OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
V 118	Continued From page	e 14	V 118			
	(C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor	nd quantity of the drug; Iministering the drug; drug is administered; and person administering the r medication changes or ded and kept with the MAR pointment or consultation				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure take-home doses of medication were administered on the written order of a physician for 1 of 9 audited clients (Client #2). The findings are:					
	-admitted 9/22/17 with Dependencephysician's orders da milligrams (mg) of me every day ending at 1 -physician's order dat home on Sunday only	ated 2/23/20 - start at 90 ethadone cascading by 10 40 mg. ed 2/24/20 - level 6 (Take				
	Administration Record 2020 revealed: -Tuesday, 2/25/20 - T 100 mg.	Client #2's Medication ds for February 2020 - May ake Home (TH) exception -				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMPLETED
		MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MEDMAR	K TREATMENT CENTER	S MURPHY 7540 US	HIGHWAY 64		
		BRASST	OWN, NC 28902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
V 118	Continued From page	e 15	V 118		
	-Thursday, 3/12/20, 1	Fuesday, 3/17/20, , and Thursday, 3/19/20 - TH			
	Interview attempted on 9/3/20 with Client #2 but he refused.				
	Director (TCD) revea -the above dates wer required doctor appro treatment. -this was done throug function in their comp	e exceptions that only by all due to his time in ghat the grant exceptions			
		and 10/28/20 of the Plan of 28/20 and signed by the TCD			
		ion will the facility take to he consumers in your care?			
	V105/V112				
	Treatment Plan due of daily basis through the medical record system	rector ("TCD") will monitor dates and signatures on a se facility's new [electronic m] and signature alert page. ecord system] is the facility's ord system.			
	2020 was accepted p TCD at the facility. No accepted other than t are currently being ac referring all admission	ion/transfer accepted in April prior to the hire of the current on new admissions were the one admission, and none accepted. The facility is n inquiries to other OTP's ograms] or OBOT's [Office			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		MHL022-017	B. WING			R-C 0/28/2020
	ROVIDER OR SUPPLIER  K TREATMENT CENTER	S MURPHY 7540 L	T ADDRESS, CITY, STATE  JS HIGHWAY 64  STOWN, NC 28902	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Based Opioid Treatm continue this practice that the facility can retain the facility was previous suspension of Admis prohibition of treating who are not admitted of October 27, 2020, calls concerning Gue assist in providing the information regarding Arrangements have be guest doser to receive clinic. As of October 2 guest dosing with this one patient that was expected to the control of the co	ent]. The facility will until notified by the state sume admissions.  ously not aware that the sions order also included a guest dosing individuals as patients of the facility. As the facility will now direct all st Dosing to the TCD to c home clinic with clinics in the area. Deen made for the current de guest dosing at a different 29, 2020 there will be no de facility, there is currently guest dosed at the facility on or received take homes  EKG [electrocardiogram]	V 118			
	doctor's order or at the that dose at the clinic Results of the EKG or documented in the pareviewed this with the	e next clinic visit for patients bi-weekly or monthly. r a patient's refusal will be				
	clinics that are able to nurse is located in Bla name] was hired Mar her multi state LPN (I license August 20, 20	has nurses from sister o cover if needed. One airsville, Georgia, [Nurse's ch 26, 2020 and obtained Licensed Practical Nurse) 119. [Nurse] agreed to assist ed upon hire. Three nurses				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL022-017	B. WING			R-C / <b>28/2020</b>
	ROVIDER OR SUPPLIER K TREATMENT CENTER	7540 US	ADDRESS, CITY, STAT HIGHWAY 64 TOWN, NC 28902	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 118	from the Durham clin October 28, 2020 to a facility should the nee name, license numbe Agreements were ma in Georgia] and the [r Carolina] should the l unable to accommod patients.  V235  Each staff member is annually thereafter th Love Group, which m requirements for grou Assessing Opioid Abi the state's requireme and Harm Reduction Treatment for Opioid requirements for with All current staff have Training completion is monthly.  [TCD]- Assessing Op completed 07/23/202 Learning to L 07/27/2020 - Group Medication-A Addiction completed syndrome  [Counselor #3] Asse Families completed 0 09/11/2020 - Family  [Counselor #2] (No loc	ic have agreed as of assist with coverage at this ed arise: [three Nurses' ers and expiration dates]. Ide with the [name of clinic name of clinice in North Blairsville, Georgia clinic be ate the facility's clinic  assigned upon hire and e trainings: Learning to eets the states up therapy training; and/or Medication Assisted Addiction, both course meet drawal syndrome training. completed these trainings is monitored by the TCD  ioid Abuse in Families 0 - Family ove Groups completed 07/23/2020 - withdrawal  essing Opioid Abuse in 12/19/2020, 08/04/2020,	V 118			
	Assessing Opioid Abi 02/18/2020 - Family	use in Families completed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED		
		MHL022-017		B. WING		l l	R-C 0/28/2020
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	RS MURPHY		IIGHWAY 64 WN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCI CY MUST BE PRECEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pag	e 18		V 118			
	to Love Groups com	pleted 02/27/2020 - 0	Learning Group				
	V237						
			as well				
	V238						
	TCD is monitoring cl [electronic medical re the facility's Complia facilitates a discussion meeting regarding the meeting clinical cont month.	ecord system] report ince Dashboard. TCI on during each week ne each counselor's p	s and ) ly staff progress				
	An Admission Check 07/14/2020 which is the TCD at the end of the order suspending. The TCD will review within 1 business day documentation and rincluding dual enrolled documentation will be clinic visit.	required to be submit of intake day for revie g admissions is remo- each new intake rec y to ensure that all ne requirements are mediment. Any missing	itted to ew once oved. ord to eccessary t,				
	TCD will develop a liper month counseling review this list with the patients on this list, with medical record system counseling. Counseling that all patier	g by 11/7/2020. TCD ne counseling team. will be flagged in [ele em] for 2x per month ors will review the lis	) will All ctronic				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		LETED
		MHL022-017	B. WING			-C <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, ST	TATE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY 754	0 US HIGHWAY 64			
		BRA	ASSTOWN, NC 2890	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 19	V 118			
	requirement.					
	UDS will be obtained monthly form each patients. Any discrepancies will be documented in the patient's record.					
	dates. TCD will monit checking off patients UDS for the month. C any patient missed pr Counselors will flag th	thly patient roster with UDS for the list on a daily basis, who have met the required on the 20th of each month, if for to the 20th, TCD/ne patient to submit a UDS ne clinic. This list will be				
	V118					
	order section of [elect system], the doctor w orders if needed. The alerts daily to insure of exceptions, have bee unsigned at the end of contact the doctor to orders will be signed hours. TCD/Nursing v	rill be contacted for verbal a TCD will review medical doctor's orders, including an signed. If orders are of the day the TCD will sign the order. All verbal by the physician within 72 will monitor exceptions on a ll be contacted whenever and				
	Describe your plans t happens.	o make sure the above				
	will continue to perfor for compliance. The facility's counseld patient records weekl	of OTP Compliance Manager in internal audits to assess ors will each audit at least 2 by. The TCD will perform at a on patient records monthly.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLET	
		MHL022-017	B. WING		R-C <b>10/28</b> /	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	IIGHWAY 64 WN, NC 28902	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 20	V 118			
	Program, counselors internal charts by 11/include treatment plai patients need clinical. The facility's [electron Compliance Dashboa implemented in Septe staff to monitor Treatments of the monitor Treatments in the completed, Treatments in the completed, Treatments implementation.  TCD will review assign Love Groups and Assign additional requirements and assign additional requirements by 11/0 are needed, all staff without them by 11/15/2020."  This deficiency constitution of the completed of the complete	and TCD, will audit all 15/2020 for compliance to a signatures and which contact twice per month.  Inci medical record system] and that the clinic ember, 2020 allows for all ment Plans never at Plan due dates and at current and last month and last month UDS, and due dates. The TCD is liance Dashboard daily since  Intended trainings, Learning to sessing Opioid Abuse in at they meet North Carolina at they meet North Carolina before trainings to meet 6/2020. If additional trainings will be require to complete  Itutes a re-cited deficiency.  To clients with a primary Dependence. One client had lays of medication with no exphysician granted TH cility computer system, but This failure constitutes a Type A1 rule violation				
		y of \$500.00 per day is correct within 23 days.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
					R-C
		MHL022-017	B. WING		10/28/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
MEDMARI	K TREATMENT CENTERS	S MURPHY	HIGHWAY 64 OWN, NC 28902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 233	Continued From page	21	V 233		
V 233	27G .3601 Outpt. Opi	od Tx Scope	V 233		
	individual an opportur changes in his lifestyl other medications appreatment in conjuncti rehabilitation and med (b) Methadone and of for use in opioid treatment in conjuncti detoxification and rehopioid dependent indi (c) For the purpose of and other medications treatment shall be addoses for a period nor (d) For individuals wiphysiologically addict least one year before methadone and other use in opioid treatment maintenance treatment methadone and other use in opioid treatment dispensed in excess of	bid treatment facility vices designed to offer the nity to effect constructive the by using methadone or proved for use in opioid on with the provision of dical services. Ther medications approved ment are also tools in the abilitation process of an vidual. If detoxification, methadone approved for use in opioid ministered in decreasing to exceed 180 days. The a history of being the dot an opioid drug for at admission to the service, medications approved for at may also be used in			
	facility failed to provid medical providers for (Clients #1, #4, and # dosing was provided	ews and interviews, the e coordination of care with 3 of 9 audited clients 9); and failed to ensure			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
					R-C
		MHL022-017	B. WING		10/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MEDMAR	K TREATMENT CENTER:	S MURPHY	IIGHWAY 64		
			WN, NC 28902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 233	Continued From page	22	V 233		
	(Clients #1, #2, #3, #4 findings are:	4, #6, #7, #8, and #9). The			
	Finding #1:				
	-admission date 12/13 -diagnosis of Opioid II -2/28/20 - physician or needs scheduling for -3/6/20 - physician or scheduling for EKG4/27/20 - an EKG wa  Review on 9/25/20 of -admission date 12/3/ -diagnosis of Opioid II -2/20/20 - physician of schedule EKG4/10/20 - physician of	Dependence. orders 110 mg methadone - Electrocardiography (EKG). ders 110 mg - needs as done. Client #4's record revealed:			
	-5/22/20 - an EKG wa	s done.  Client #9's record revealed:			
	-admission date 1/17/ -diagnoses of Diabete Dependence3/5/20 - physician or schedule EKG3/11/20 - physician or schedule EKG4/3/20 - physician or done.	ders - 115 mg methadone - rders 125 mg - need to ders 140 mg - get EKG			
	Interview on 10/12/20	with the Treatment Center			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE COMF	SURVEY
						₹-C
		MHL022-017	B. WING		10	/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
MFDMAR	K TREATMENT CENTERS	S MURPHY 7540 US I	HIGHWAY 64			
III DIII AN	THEATMENT SERVER	BRASSTO	OWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 233	Continued From page	23	V 233			
	for their EKGs and thi timesno they have an EKC	ents out to other providers is was why it too so long at a machine in the facility and ore timely when ordered.				
	Finding #2:					
	Nurse (LPN) revealed on Thursday, 2/20/20 bad, however she was the dayshe let the Former D feeling well and the F setting up guest dosirieshe ended up in the surgery and was not a Saturday or Sunday (the facility Registered vacation during this time a sister facility agree over the weekendall the clients were not the sister cliniconce the clients start refused to dose them	D, she was hurting pretty is able to finish dosing for director know she wasn't cormer Director started ing.  Thospital for emergency able to work Friday, 2/21/20 - 2/23/20). In the director of the following directors was out of town on the director of the following director of				
	-one time the facility value a medical emergency	ent to the sister clinic to				
	Opioid Treatment Aut	and 10/12/20 with the State hority (SOTA) revealed:				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL022-017	B. WING			-C <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, ST.	ATE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MUDDUY 754	0 US HIGHWAY 64			
WIEDWAK	K IKEAIMENI CENIEK	BR	ASSTOWN, NC 2890	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 233	Continued From page	e 24	V 233			
		and the facility had no nurse ency back-up plan.				
	Records (MARs) for 0 #7, #8 and #9 revealed	f Medication Administration Clients #1, #2, #3, #4, #6, ed: ses of methadone from				
	TCD revealed: -the missed doses or they were not dosed -this happened before Julyas far as she could t #2 did not dose 2/21/ -Clients #1, #3, #4, # their sister clinic on 2 -the above clients we 2/23/20 because the refusedthe sister clinic remains the event of another of -the nurse that refuse thereof the 111 clients en	e she became the TCD in ell from the records Client (20-2/23/20). 6, #7, #8 and #9 dosed at (/21/20). The re not dosed on 2/22/20 or nurse at the sister facility wins to be their first choice in				
	revealed: -he was very upset w -he gave orders to gu have honored thisthe most important of	o with the Medical Director with the sister clinic. west dose and they should client was their pregnant ed she was able to get				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE S COMPL	
				_		R-	.C
		MHL022-017		B. WING		10/2	8/2020
NAME OF P	ROVIDER OR SUPPLIER	5	STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	7540 US HIG BRASSTOW	SHWAY 64 'N, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(X5) COMPLETE DATE
V 233	-he was not aware of from not being dosed -clients came in that "short symptoms" fro	any huge repercussions	d	V 233			
V 225	NCAC 27G .0201 Go	verning Body Policies orrect a Type A1 rule		V 235			
V 200	10A NCAC 27G .360 (a) A minimum of on counselor or certified to each 50 clients and on the staff of the fact this prescribed ratio, individual who is cert unavailability of certification requirem months from the date (b) Each facility shall member on duty train (1) drug abuse (2) symptoms (1) drug addiction. (c) Each direct care continuing education the following: (1) nature of ac (2) the withdram (3) group and for certification or certification requirem months from the date (b) Each facility shall member on duty train (1) drug abuse (2) symptoms (2) symptoms (3) symptoms (4) following:	as STAFF e certified drug abuse substance abuse counse d increment thereof shall ility. If the facility falls beland is unable to employ a ified because of the ied persons in the facility ay employ an uncertified this employee meets the ents within a maximum of e of employment. I have at least one staff ied in the following areas: withdrawal symptoms; ai of secondary complication staff member shall receiv to include understanding ddiction; wal syndrome; family therapy; and iseases including HIV,	be ow an s f 26	V 255			

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	10/20/2020
		7540 US H	IGHWAY 64	, 2 3332	
MEDMAR	K TREATMENT CENTER	S MURPHY	WN, NC 28902	!	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 235	Continued From page	26	V 235		
	facility failed to ensure continuing education 3 of 3 audited staff (TCD), Counselor #2 findings are:  Review on 9/18/20 of file revealed: -hired 8/30/188/4/20 - Assessing C-8/5/20 - Learning to I	ew and interviews, the e all staff received to include family therapy for Freatment Center Director and Counselor #3). The  Counselor #2's employee			
	file revealed: -hired 9/3/208/4/20 - Assessing C -8/4/20 - Learning to I	Counselor #3's employee  pioid Abuse in Families.  Love Groups. g specific to family therapy.			
	revealed: -hired 7/6/207/23/20 - Assessing -7/27/20 - Learning to -there was no training	specific to family therapy.			
	-these were trainings system that everyone annually. -she felt the above tra Family Therapy requi	red training. s curriculum to determine if it			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,
		7540 US H	IIGHWAY 64		
WEDWAR	K TREATMENT CENTERS	BRASSTO	WN, NC 28902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 235	Continued From page	27	V 235		
	This deficiency is cross NCAC 27G .0201 Go (V105) for failure to coviolation.				
V 237	27G .3604 (A-D) Outp	ot. Opiod - Operations	V 237		
	days per week, 12 mo weekend and holiday hours shall be schedulthe client.  (b) Compliance with Mental Health Service or The Center for Sub (CSAT) Regulations. certified by a private ragency, that has been of the United State De Human Services and all SAMHSA Opioid Detoxification Treatmeregulations in 42 CFF incorporated by refere amendments and edit available from the CS 5600 Fishers Lane, Rocost.  (c) Compliance With facility shall be current Federal Drug Enforce shall be in compliance Administration regular treatment programs of and Drugs, Part 1300 incorporated by refere	onths per year. Daily, medication dispensing alled to meet the needs of the Substance Abuse and es Administration (SAMHSA) estance Abuse Treatment Each facility shall be non-profit entity or a State of approved by the SAMHSA epartment of Health and shall be in compliance with erugs in Maintenance and ent of Opioid Addiction at Part 8, which are ence to include subsequent cions. These regulations are AT, SAMHSA, Rockwall II, ockville, Maryland 20857 at DEA Regulations. Each tly registered with the ment Administration and entitions pertaining to opioid odified in 21 C.F.R., Food			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STAT	E, ZIP CODE	
MEDMAR	K TREATMENT CENTERS	S MIIDDHY 7540 US	HIGHWAY 64		
WILDWAN	K INLAIMENT CENTER	BRASS	TOWN, NC 28902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 237	Continued From page	e 28 ited States Government	V 237		
	published rate. (d) Compliance With Each facility shall be a Carolina State Author DMH/DD/SAS, which the Secretary of Healt exercise the responsi state for governing the an opioid drug, includ monitoring compliance related to scope, staff monitoring compliance 102-321. The reference	f, and operations, and for e with Section 1923 of P.L. nced material may be bstance Abuse Services			
	facility failed to ensure with State Authority R  Interviews on 9/22/20 with the State Opioid revealed: -in February there wa the facility had no nur-they were not contact notification of having for 3 daysthere was no emergenumerous clients mistathe Central Registry	ews and interviews the e they were in compliance degulations. The findings are: 1, 10/12/20 and 10/19/20 Treatment Authority (SOTA)  as a medical emergency and use to dose clients. Acted immediately regarding no one to dose their clients  bency back-up plan. Assed their dose. Asset dose dose dose dose dose dose dose dose			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE :	
ANDILAN	or dorace more	IDENTIFICATION NOMBER.	A. BUILDING: _			
		MHL022-017	B. WING		l l	-C <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	S HIGHWAY 64 TOWN, NC 28902	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 237	-one time the facility of a medical emergency a lot of people just widose.  -"I just went to the house attempted and of No calls were returned linterview on 9/3/20 with ware attempted and of No calls were returned linterview on 9/3/20 with Nurse (LPN) revealed on Thursday, 2/20/20 bad, however she was the day.  -she let the Former Diffeeling well and the Fisetting up guest dosinishe ended up in the surgery and was not staturday or Sunday (10 of the facility Registere vacation during this time a sister facility agreed over the weekend.  -all the clients were in the sister cliniconce the clients start facility the nurse refusion the clients were them for the clients were the clie	was not able to dose due to ordent to the sister clinic to use. I was fine."  face-to-face with clients on 10/12/20 via telephone.  with the Licensed Practical diagram of the sable to finish dosing for the sable to finish dosing for the sable to work Friday, 2/21/20 - 2/23/20).  If Nurse was out of town on me.  If to guest dose their clients of the dose them.  If told to go to the emergency and the sister sed to dose them.  If Medication Administration clients #1, #2, #3, #4, #6, ed:  If Medication Administration clients #1, #2, #3, #4, #6, ed:  If Medication Administration clients #1, #2, #3, #4, #6, ed:  If Sees of methadone from	V 237			
	Interviews on 10/12/2	o and 10/16/20 with the				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		R-0	_
		MHL022-017	B. WING		I	8/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MEDMARI	K TREATMENT CENTER	S MURPHY	HIGHWAY 64			
III DIII A	THEATMENT SERVER	BRASST	OWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 237	Continued From page	e 30	V 237			
	-the missed doses on they were not dosed -this happened before JulyClient #2 did not dos-Clients #1, #3, #4, # their sister clinic on 2 -the above clients we 2/23/20 because the refusedthe sister clinic remathe event of another entry entry the nurse that refused thereof the 111 clients entry not possible to determissed dosing.  This deficiency is cro	e she became the TCD in  the 2/21/20-2/23/20. 6, #7, #8 and #9 dosed at //21/20. The not dosed on 2/22/20 or resurred at the sister facility  thins to be their first choice in the emergency. The dose no longer worked  the rolled in the program it was remaine how many clients  as referenced into 10 A verning Body Policies				
V 238	27G .3604 (E-K) Out	ot. Opiod - Operations	V 238			
	TREATMENT. OPER  (e) The State Author approval on the follow (1) compliance law and regulations; (2) compliance standards of practice (3) program str service delivery; and (4) impact on the	ity shall base program ving criteria: with all state and federal with all applicable ; ucture for successful ne delivery of opioid the applicable population.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL022-017	B. WING		R-C <b>10/28/2020</b>
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
MEDMARK TREATMENT CENTERS MU	JRPHY 7540 US HI BRASSTO	GHWAY 64 NN, NC 28902		
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
following conditions:  (A) Level 1. During continuous treatment, the limited to a single dose eas shall ingest all other doses the clinic;  (B) Level 2. After a continuous program comp granted for a maximum of and shall ingest all other cat the clinic each week;  (C) Level 3. After 1 treatment and a minimum continuous program comp client may be granted for a take-home doses and shall under supervision at the continuous at	take-home use of cations approved for cations approved for cations approved for cion must meet the residence of the compliance and compliance during simmediately preceding dition, during the first during the first during sessions per residence and in all subsequent ment a patient must counseling session per lity are subject to the the first 90 days of extake-home supply is and week and the client are under supervision at the minimum of 90 days of coliance, a client may be foliance, a client may be foliance, a client may be foliance at level 2, a a maximum of four call ingest all other doses clinic each week; 70 days of continuous of 90 days of coliance at level 3, a a maximum of five	V 238		

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MHL022-017  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7540 US HIGHWAY 64 BRASSTOWN, NC 28902   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 32  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 one year of continuous program compliance at level 5, a client may be granted for a maximum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 133		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7540 US HIGHWAY 64  BRASSTOWN, NC 28902  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 32  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				P WING		
MEDMARK TREATMENT CENTERS MURPHY  Total 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)  V 238  Continued From page 32  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			MHL022-017	B. WING		10/28/2020
MEDMARK TREATMENT CENTERS MURPHY  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) COMPLETE DATE  V 238  Continued From page 32  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	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CX4) ID   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE      V 238	MEDMARI	K TREATMENT CENTERS	S MURPHY 7540 US HI	GHWAY 64		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 32  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			BRASSTO	NN, NC 28902	!	
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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE
(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	V 238	Continued From page	e 32	V 238		
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 compiliance, 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. 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	V 238	under supervision at the (E) Level 5. Aftereatment and a minimizent continuous program of granted for a maximuland shall ingest at leasupervision at the clinic (F) Level 6. Aftereatment and a minimizent may be granted take-home doses and dose under supervision days; and (G) Level 7. Aftereatment and a minimizent may be granted take-home doses and dose under supervision days; and (G) Level 7. Aftereatment and a minimizent may be granted for a maximuland shall ingest at leasupervision at the clinic (2) Criteria for Find Reinstatement of Take (A) A client who tests possibility (B) A client who tests possibility (B) A client who screens within the sail all take-home eligibility (C) The reinstate eligibility shall be determined by the continuous treatment the applicable mandal exceptional circumstate.	the clinic each week; iter 364 days of continuous mum of 180 days of compliance, a client may be im of six take-home doses ast one dose under nic each week; iter two years of continuous mum of one year of compliance at level 5, a if or a maximum of 13 if shall ingest at least one on at the clinic every 14  Ifter four years of continuous mum of three years of compliance, a client may be im of 30 take-home doses ast one dose under nic every month. Reducing, Losing and e-Home Eligibility: ixe-home eligibility is reduced dence of recent drug abuse. Sitive on two drug screens d shall have an immediate by one level of eligibility; or tests positive on three drug me 90-day period shall have ty suspended; and itement of take-home ermined by each Outpatient ogram. to Take-Home Eligibility: ite first two years of who is unable to conform to intory schedule because of ances such as illness,	V 238		

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		MHL022-017	B. WING		10/28/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER:	S MURPHY	HIGHWAY 64			
	T		OWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
V 238	Continued From page		V 238			
	by the State authority found to be responsible Except in instances in verifiable physical dis of 13 take-home dose period during the first treatment.  (B) A client who applicable mandatory verifiable physical dis additional take-home authority. Clients who take-home eligibility of disability may be grar 30-day supply of take make monthly clinic with take-home dosages medications approved addiction shall be autiphysician on an indivito the following:  (A) An additional methadone or other intreatment of opioid acto each eligible client treatment) for each streatment of opioid acto any eligible client be restriction shall not appreciation of the proposition of the proposit	Dosages For Holidays: of methadone or other d for the treatment of opioid horized by the facility idual client basis according all one-day supply of nedications approved for the diction may be dispensed (regardless of time in tate holiday. an a three-day supply of nedications approved for the diction may be dispensed because of holidays. This oply to clients who are medications at Level 4 or Medications For Use In the risks and benefits of				
	Except in instances in verifiable physical dis of 13 take-home dose period during the first treatment.  (B) A client who applicable mandatory verifiable physical dis additional take-home authority. Clients who take-home eligibility of disability may be grar 30-day supply of take make monthly clinic version (4) Take-Home Take-home dosages medications approved addiction shall be autication shall be autication on an indivito the following:  (A) An additional methadone or other intreatment of opioid actor each eligible client treatment of opioid actor each eligible client the restriction shall not appreciately withdrawal From Opioid Treatment. The withdrawal from methal	ability, there is a maximum es allowable in any two-week two years of continuous or is unable to conform to the eschedule because of a ability may be permitted eligibility by the State or are granted additional due to a verifiable physical ented up to a maximum enhome medication and shall disits.  Dosages For Holidays: of methadone or other different to for the treatment of opioid horized by the facility idual client basis according all one-day supply of medications approved for the ediction may be dispensed (regardless of time in that holiday.  an a three-day supply of medications approved for the ediction may be dispensed (redactions approved for the ediction may be dispensed of the edications approved for the ediction may be dispensed of the edic				

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DIVISION	n Health Service Regu		1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
						_
			B. WING		R-(	
		MHL022-017	5. WING		10/2	8/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			IGHWAY 64			
MEDMARI	K TREATMENT CENTERS	S MURPHY	WN, NC 28902	•		
			VVIN, NC 20902			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	1120021101110111		IAG	DEFICIENCY)	=	
V 238	Continued From page	e 34	V 238			
	discussed with each	client at the initiation of				
	treatment and annual	<del>-</del>				
		Random testing for alcohol				
	•	be conducted on each				
		nt client with a minimum of				
	•	each month of continuous				
	treatment. Additional	-				
	three-month period of					
		least one random drug test				
	will be observed by pr	rogram staff. Drug testing is				
	to include at least the	following: opioids,				
	methadone, cocaine,	barbiturates,				
	amphetamines, THC,	benzodiazepines and				
	alcohol. Alcohol testi	ng results can be gathered				
	by either urinalysis, b	<del>-</del>				
	alternate scientifically					
		estrictions. No client shall				
		ne facility while physically				
		nadone or other medications				
		pioid treatment unless the				
		opportunity to detoxify from				
	the drug.	opportunity to detoxily ironi				
	•	rovention All licensed				
		revention. All licensed ction treatment facilities				
	which dispense Metha					
		,				
		ethadol (LAAM) or any other				
		nt approved by the Food and				
	•	or the treatment of opioid				
		to November 1, 1998, are				
		in a computerized Central				
		at clients are not dually				
	•	direct contact or a list				
		oid treatment programs				
		ile radius of the admitting				
	program. Programs a	are also required to				
	participate in a compu					
		iting List Management				
		d by the North Carolina				
	State Authority for Op					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLE	
		MHL022-017	B. WING		R <b>10/2</b>	C <b>8/2020</b>
	ROVIDER OR SUPPLIER  K TREATMENT CENTER	S MURPHY 7540 US H	DRESS, CITY, STA IIGHWAY 64 IWN, NC 28902		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 238	Opioid Treatment Prorequired to establish control plan as part of shall document the plant procedures. A diversithe following element (1) dual enrolling that consist of client of program contacts, paregistry or list exchand (2) call-in's for or solid dosage form (3) call-in's for (4) drug testing review of the levels of medications approver addiction; (5) client attentions.	Plan. Outpatient Addiction grams in North Carolina are and maintain a diversion of program operations and an in their policies and ion control plan shall include sometiment prevention measures consents, and either reticipation in the central ges; bottle checks, bottle returns call-in's; drug testing; a results that include a for the treatment of opioid dance minimums; and to ensure that clients	V 238			
	facility failed to ensur continuous treatment minimum of two coun and after the first yea least one counseling audited clients (Clien- failed to conduct a mid drug screen (UDS) ea clients (Client #2); an audited clients (Client	as evidenced by: ews and interviews, the e that during the first year of each client attended a seling sessions per month r of treatment attended at session per month for 6 of 9 ts #3, #5, #6, #7, #8 and #9); nimum of one random urine ach month for 1 of 9 audited d failed to ensure 3 of 9 ts #1, #5 and #6) were not a 75 miles radius. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED	
		MHL022-017	B. WING		l l	28/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
MEDMAR	K TREATMENT CENTER	S MURPHY	HIGHWAY 64 OWN, NC 28902	<u>.</u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 238	Continued From page	e 36	V 238				
	findings are:						
	Finding #1:						
	-admitted on 2/7/20 w Dependence and Bip	g sessions not provided for					
	-admitted on 4/28/20 Dependence and Bip	/8/20 for Client #5 revealed: with diagnoses of Opioid olar Disorder. g session not provided for					
	-admitted on 2/7/20 w Dependence and Hep -an assessment date former client who was readmission."	d 2/7/20 reflected he was a s discharged and "seeking g sessions not provided for					
	-admitted on 1/3/20 w Dependence. -bimonthly counseling March, April, May, Ju Record review on 10/ -admitted on 1/3/20 w Dependence and Chi -an assessment date former client who left was re-admitted.	/8/20 for Client #7 revealed: with diagnosis of Opioid g sessions not provided for one, July and August 2020. /8/20 for Client #8 revealed: with diagnoses of Opioid ronic Neuropathy Pain. d 1/9/20 reflected he was a program in July 2019 and g sessions not provided for and July 2020.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL022-017	B. WING			R-C 0/ <b>28/2020</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	,	
MEDMAR	K TREATMENT CENTERS	S MURPHY	HIGHWAY 64 OWN, NC 28902			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 238	-admitted on 1/17/20 Dependence and Dial -bimonthly counseling February, March, May 2020.  Interview on 9/3/20 w -she had a caseload of -there was too much y responsible to have fr follow-up with help de  Interview on 9/3/20 w -she was now trying to month no matter how treatmentshe had been doing? Treatment Center Dire 2020she may see the clie minutes, or 4 times a  Interviews on 9/24/20 the TCD revealed: -Clients #3, #5, #7, ar have counseling two to -she thought Client #6 month since he had b since April 2018she thought Client #8 a month since he had July 2017.  Finding #2:  Record review on 10/	8/20 for Client #9 revealed: with diagnoses of Opioid betes. g sessions not provided for y, June, July and August  ith Counselor #1 revealed: of 32 clients. going on - she was cont desk duty and to esk tickets.  ith Counselor #2 revealed: o see clients an hour a long the client had been in  this since the new ector (TCD) started in July  nt 2 times a month for 30 month for 15 minutes.  , 10/1/20 and 10/15/20 with  nd #9 were all required to	V 238			
	Dependence.	/10/20 with results of "ONS				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<del></del>		
		MHL022-017	B. WING		R-C <b>10/28</b> /	2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MEDMAR	K TREATMENT CENTER	S MURPHY	IIGHWAY 64 WN, NC 28902	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 238	-she was not made an in Julyit was the counselor's another UDS.  Findings #3:  Record review on 9/2 -admitted on 12/13/19 Dependencedual enrollment check of 7/13/20.  Record review on 9/2 -admitted on 4/28/20 Dependence and Bipulated on 4/28/20 Dependence and Bipulated on 2/7/20 where the continuation of 1/24/20.  Interviews on 9/24/20 the TCD revealed: -the person who compresponsible to complete checkthis was usually done.	with the TCD revealed: ware of Client #2 QNS result s responsibility to schedule  4/20 of Client #1 revealed: with diagnosis of Opioid k was not completed until  4/20 for Client #5 revealed: with diagnoses of Opioid olar Disorder. k was not completed until  8/20 for Client #6 revealed: with diagnoses of Opioid olar Disorder. k was not completed until  8/20 for Client #6 revealed: with diagnoses of Opioid olar Disorder. k done prior to admission  9, 10/1/20 and 10/15/20 with pleted the client's intake was ete the dual enrollment	V 238	DEFICIENCY)		
	(V105) for failure to conviolation.					

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
	MHL022-017	B. WING	R-C <b>10/28/2020</b>

NAME OF PROVIDER OR SUPPLIER  MEDMARK TREATMENT CENTERS MURPHY		STREET ADDRESS, CITY, STATE, ZIP CODE					
		7540 US HIGHWAY 64 BRASSTOWN, NC 28902					
							(X4) ID PREFIX TAG

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