STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-136	A. BUILDING: _____ B. WING _____	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON TREATMENT ASSOCIATES	310 MURPHY DRIVE LEXINGTON, NC 27295

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6/14/21. The complaints were unsubstantiated (intake #NC00165203 and intake #NC00165615). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.	V 000	DHSR - Mental Health JUN 25 2021 Lic. & Cert. Section	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures	V 109	The following has been or will be implemented related to the cited deficiency -Retrain nursing staff member on dosing policies related to medication spills and handling. -RN will meet with NP to review med errors for the purpose of providing feedback and training related to errors. - Nursing staff will contact MD, PA or NP for guidance and supervision after a dosing error. - NP, PA or MD will review all dosing errors.	8/13/2021

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V 109	Continued From page 1 for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 5 audited Qualified Professionals (Registered Nurse #1 (RN #1) and the Program Director (PD)) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Finding #1: Review on 6/9/21 of the facility's "critical incident report forms" from 3/26/21-6/3/21 revealed: - RN #1 had completed eight "critical incident reports" which he used to document medication errors by him on 3/26/21; 4/12/21; 4/13/21; 4/19/21; 5/17/21; 5/25/21; 5/28/21; and 6/3/21 - His medication errors included, spilling Methadone as he prepared take home bottles or when cleaning facility equipment; preparing a client's dose improperly (prepared liquid instead of a "disk"); counting out more "disks" than needed when preparing take home bottles and not following the facility's dosing protocol after a client had missed seven days - None of the medication errors had resulted in a negative outcome for any of the clients involved - The Program Director (PD) was notified of	V 109		

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V 109	Continued From page 2 each of the incidents and after each incident, the PD instructed and/or encouraged the RN #1 "to be mindful; to be more careful; to pay more attention; and to take their time..." - No documentation which indicated any other actions were taken by the PD regarding RN #1's work performance Review on 6/10/21 of Registered Nurse #1's (RN #1's) record revealed: - A hire date of 3/23/21 - A job description of a Registered Nurse Interviews on 6/10/21 and on 6/14/21 with RN #1 revealed: - He had worked at the facility since March of 2021 and had worked at a sister facility prior to his employment at this facility - He had several medication errors since becoming employed with the facility as a RN - "I remember once I started here, there was an issue with Methadone spills. I don't know how it happened, but it did, I try to be diligent." - "The errors have not happened since, some errors were with the disk. So now I count the disks out loud." - "Basically, the only errors I have had was with the Methadone. It was not with any of the clients ..." - No one (in management) had sat down with him to discuss the number of medication errors he had had over the past three months - "...My co-workers have been very helpful in making sure I slow down." - "We don't have like nursing meetings with the Program Director." - "We don't have a Director of Nursing either, the physician is only here on Mondays and the Nurse Practioner is here two days a week, we (the nursing staff) do not have clinical supervision	V 109		

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V 109	Continued From page 3 with them..." - RN #1 reported he participated in meetings with the nursing staff and the counselors to discuss difficult clients and clients with health issues every Thursday - "I guess it would be a good time for the nurses to discuss dosing errors then (Thursday meetings)." Finding #2: Interview on 6/11/21 with the PD revealed: - The facility did not employ a Director of Nursing - The nursing staff did not meet with the MD or the NP for clinical supervision - "[RN #1] and all the facility staff have monthly supervision with me, but I have not addressed any of the dosing errors, I am not a registered nurse." - She was aware of the number of "critical incident reports" completed by RN #1 over the past three months - She realized it was not normal to have as many incidents as RN #1 had had and fortunately, no client had been negatively impacted by RN #1's errors She stated she had encouraged RN #1 to take his time when preparing take home medications - "I tell him to pay attention." - When asked if anything else had been done to address RN #1's work performance, the PD reported no other actions had been taken to address his performance - "I would have to get with my supervisor to do a Performance Improvement Plan or a write up on him, I have not sat down and met with him." - "I could have the NP or the MD work with him. I have not thought of that...I do see a need	V 109		

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V 109	Continued From page 4 for something to be done about all the medication errors, I could have our NP sit down with him..."	V 109		