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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-065			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHI 063-065	B. WING		08/19/2021	
	OVIDER OR SUPPLIER	STREET A 20 PAGE 20 PAGE	L DDRESS, CITY, STATE DRIVE RST, NC 28374	, ZIP CODE		5/15/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMF THE APPROPRIATE DA	
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on August 19, 2021. Deficiency cited.					
	This facility is license category 10A NCAC Outpatient Opioid Tre					
	The facility was serve	ing: 474 clients				
V 235	27G .3603 (A-C) Out	tpt. Opiod Tx Staff	V 235			
	counselor or certified to each 50 clients an on the staff of the fac this prescribed ratio, individual who is cert unavailability of certifi- hiring area, then it m person, provided that certification requirem months from the data (b) Each facility shal member on duty train (1) drug abuse (2) symptoms to drug addiction. (c) Each direct care continuing education the following: (1) nature of a (2) the withdra (3) group and	the certified drug abuse d substance abuse counselor d increment thereof shall be cility. If the facility falls below and is unable to employ an tified because of the fied persons in the facility's ay employ an uncertified t this employee meets the nents within a maximum of 26 e of employment. Il have at least one staff ned in the following areas: e withdrawal symptoms; and of secondary complications staff member shall receive to include understanding of ddiction; wal syndrome; family therapy; and diseases including HIV,				
	Ith Service Regulation	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

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Division of Health Service Regul STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
	MHL063-065		B. WING		08/19/2021		
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
AROLIN	A TREATMENT CENTER	R OF PINEHURST	E DRIVE RST, NC 28374				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN C		()	
PREFIX (EACH DEFICI		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLE DATE	
V 235	Continued From pag	e 1	V 235				
	This Rule is not met	as evidenced by:					
	Based on record reviews and interviews, the						
	facility failed to ensure a minimum of one certified						
	drug abuse counselor, certified substance abuse counselor and the Clinic Director to each 50						
	clients and increment thereof shall be on the staff						
	of the facility. The fin						
	Review of facility rec revealed:	ords on 8/17/21 and 8/19/21					
	-The facility had a current census of 474 clients.						
	-The facility currently had eight full time						
	substance abuse counselors.						
		tance abuse counselors and					
	-	id a caseload over 50.					
	-Counselor #1 had a caseload of 64 clients. -Counselor #2 had a caseload of 59 clients.						
		caseload of 62 clients.					
	-Counselor #4 had a caseload of 63 clients.						
	-Counselor #5 had a caseload of 60 clients.						
	-Counselor #6 had a	caseload of 62 clients.					
		caseload of 58 clients.					
	-Clinic Director had a	a caseload of 60 clients.					
	Interview on 8/19/21 Regional Director rev	with the Clinic Director and /ealed:					
		were working as a team,					
		acititated case conferences					
	to safeguard high risk						
		recruiting for counselors. vacant counselor positions.					
		nselor with a start date of					
	-They had a policy fo	or all new patients to have 2					
	weekly contacts at a counselor.	minimum with their					
		for patients admitted beyond					
	90 days.	ior patients autilitied beyond					

STATE FORM

BDZ311

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FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
MHL063-065		B. WING		08	08/19/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
A TREATMENT CENTER	R OF PINEHURST						
(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE COMPLE D THE APPROPRIATE DATE			
Continued From page 2		V 235					
	OF CORRECTION ROVIDER OR SUPPLIER A TREATMENT CENTER SUMMARY S (EACH DEFICIENT REGULATORY OR Continued From pag -They would explore ensure they were no	OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: MHL063-065 ROVIDER OR SUPPLIER STREET A A TREATMENT CENTER OF PINEHURST 20 PAGE SUMMARY STATEMENT OF DEFICIENCIES PINEHUI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 -They would explore putting something in place to ensure they were not over admitting due to	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL063-065 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, A TREATMENT CENTER OF PINEHURST 20 PAGE DRIVE PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 2 V 235 -They would explore putting something in place to ensure they were not over admitting due to V 235	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL063-065 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE A TREATMENT CENTER OF PINEHURST 20 PAGE DRIVE PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN Continued From page 2 V 235 V 235 -They would explore putting something in place to ensure they were not over admitting due to V 235	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMING MHL063-065 B. WING 08 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08 A TREATMENT CENTER OF PINEHURST 20 PAGE DRIVE PINEHURST, NC 28374 PROVIDER'S PLAN OF CORRECTION SHOULD BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 2 V 235 V 235 V 235		

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