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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 10/04/2021. The complaints were substantiated (NC#180532, NC#180512, and NC#181236). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program.	V 000		
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		

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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 reviews and interviews, 1 of 2 current Qualifed Professionals (QP), (Director/QP) and 3 of 3 former staff, (Former Therapist #2, Former Therapist #3, and Former QP#2 failed to demonstrate knowledge skills and ability required by the population served. The findings are: Please refer to Tag V112 for information about service notes, attempted discharge planning, and diagnostic information. The following are examples of how Former QP#2 and Former Therapist#2 and Former Therapist #3 failed to demonstrate competency: -Former QP#2 did not update Decased Client (DC) #3's treatment plan with new strategies despite multiple absences, suspected relapse and a documented need for a higher level of care; -Former QP#2 did not link and coordinate services for DC#3 at discharge; -Former Therapist#2, Former Therapist#3, and Former QP#2 did not document interventions or coordination with each other regarding treatment to address the needs of DC#3.	V 109		

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V 109	Continued From page 2 The following is an example of how the Director/QP failed to demonstrate competency: -she failed to sign a letter for DC#3 that was requested by probation and forwarded to her by Substance Abuse Intensive Outpatient Program (SAIOP) staff referencing a need for a higher level of care, for 7 business days, from 3/23/21-4/2/21 and edited information in the letter; -the edited information included inaccuracies regarding lack of progress in the program, and a recommendation for a different service that was not recommended by the clinicians; -The Director/QP based her edits upon review of the client record. She had never met DC#3. Review on 9/29/21 of emails between the Director/QP and Former Therapist #2, Former Therapist#3, and Former QP#2 dated 3/25/21-4/2/21, entitled "[DC#3 initials] letter of support" revealed: -a series of emails back and forth between the SAIOP team and Director regarding a letter for DC#3's probation officer; -the initial email had a letter of support attached dated 3/23/21 regarding DC#3 sent from therapist #3 to the Director read: "March 23, 2021 To Whom it May Concern, This is a letter to inform you that [DC#3] [DC#3 Date Of Birth (DOB)] has been discharged from the Substance Abuse Intensive Outpatient Program (SAIOP) due to erratic attendance that fails to comply with an intensive outpatient program as outlined by the state of North Carolina. [DC#3] was also asked to report for a random urine drug screen (agreed upon by [DC#3] in the SAIOP intake process and review of the SAIOP service agreement on 12/21/2020) in a timely manner, but the client appeared to be	V 109		

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unable to comply with this request per her report. Client has been recommended to a higher level of care."

-the letter was edited by the Director and sent back to the team on 3/29/21 to say:
"March 23, 2021
To Whom it May Concern,
This is a letter to inform you that [DC#3] [DC#3 DOB] has been discharged from the Substance Abuse Intensive Outpatient Program (SAIOP) due to unmet expectations of engagement and inability to participate in required components of the program.
Specifically, [DC#3] was unable to attend 11 scheduled appointments of 25 in the past 90 days as of 3/29/2021. Additionally, [DC#3] was unable to commit to a random urine drug screen in a timely manner, previously agreed upon when entering the program as of 12/21/2020. At this time [DC#3] has been recommended to a different level of care that can best meet her needs in regards to stabilization and reduction of specifically mental health related symptoms."

-The final letter that was approved and sent out on 4/2/21 by Former QP#2 at 4:32pm revealed:
"March 23, 2021
To Whom it May Concern,
This is a letter to inform you that [DC#3] [DC#3 DOB] has been discharged from the Substance Abuse Intensive Outpatient Program (SAIOP) due to unmet expectations of the program as evidenced by: not attending as required, not completing urine drug screens as requested and required.
Specifically, [DC#3] did not attend 19 scheduled appointments of 38 in the past 90 days as of 3/22/2021. Additionally, [DC#3] did not complete a random urine drug screen in a timely manner,

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previously agreed upon when entering the program as of 12/21/2020.
At this time [DC#3] has been recommended to a different level of care that can best meet her needs in regards to stabilization and reduction of specifically mental health and substance use disorder related symptoms.
This different level of care could include detoxification and rehabilitation services provided within an inpatient setting and/or another intensive outpatient program that may better meet [DC#3's] needs wherein any barriers to recovery are identified and addressed."

Interview on 9/15/21 with the Former QP#2 revealed:
-she was unaware of a written policy regarding letter writing but that before anything got sent out to an outside agency, it needed a co-signature from the Director/QP;
-she reported that she "asked for a meeting about the letters but no one would respond;"
-she reported that probation asked for a letter for DC#3;
-she reported that probation asked for the letter three times, 3/23/21, again in conversation, and via text on 4/2/21;
-she reported that DC#3 had a problem with the sister facility's Adult Recovery Unit and wanted to go to a different setting, and talked about a local hospital;
-"we wanted to paint a picture to the judge that she needs a higher level of care ...the first letter would have been fine to send out;"
-she reported that Former Therapist#3 made the letter on 3/23/21 and sent it to the Director on 3/25/21 for signature;
-on 3/26/21 she reported the Director/QP sent it back with two words to be changed and modifications were made and sent it back;

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V 109	Continued From page 5 -on 3/29/21 the Director/QP sent the letter back with more edits, "with dates in the letter that the client wasn't present, and the information wasn't accurate ...the [Director/QP] wanted the letter to say different level of care vs. higher level of care;" -she reported that "[Director/QP] had never met or worked with DC#3, and recommended that DC#3 be referred to Community Support Team (CST) which would have been a disaster, and not a higher level of care;" -"we emailed on 4/2/21 and asked [Director/QP] to correct the clinical recommendation ...we are talking about a disease that kills, causes imprisonment and this probation officer needed accurate information ...we didn't need to sugar coat stuff ...it was a power struggle;" -Probation called her the morning of Friday, 4/2/21 and requested the letter. She sent the letter at 4:32pm. -DC#3 passed away that weekend on 4/5/21. Interview on 9/9/21 with Former Therapist#2 revealed: -she was terminated on 4/28/21 for HIPPA and boundary violations along with the former QP#2 and Former Therapist#3; -she wrote the letter for DC#3 and sent it to the Director/QP for DC#3's probation officer; -she reported that the letter should be in the document section of file, "if not ask the Director;" -regarding DC#3 passing away she stated: "it could have been avoided ....if we had gotten that letter to probation timely, [DC#3] could have gotten in to inpatient quicker;" -they were trying to get DC#3 in to a local hospital for inpatient treatment; -her last interaction with DC#3 was when she and Former QP#2 called DC#3 on 3/22/21; -they requested that DC#3 come in for a drug screen and DC#3 declined;	V 109		

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-"SAIOP recommendations in the letter for probation needed to be specific so that inpatient could be paid for by probation and signed by the judge;"
-she reported she spoke with the Director/QP about the importance of the letter;
-any letter going to an outside agency had to be co-signed by the Director/QP and she "was supervising my license at the time."

Interview on 9/8/21 with Former Therapist#3 revealed:
-he reported that he had been the lead staff in SAIOP and was with the agency for 14 years;
-he got terminated on 4/28/21 with the Former QP#2 and Former Therapist#2 due to "boundary issues;"
-"in this field ...nobody wants to have an oh s**t moment ...you don't want that ...and this was the Director's, oh s**t moment ....after she (DC#3) died, all the dominoes fell;"
-"[DC#3] was discharged from SAIOP and we were trying to do a placement for [DC#3] at a local hospital ... and we needed to get a letter for the probation officer;"
-reported that DC#3's filed had been put through a "legal filter" when survey began on 9/8/21
-"the [Director/QP] never met [DC#3], "She never sat in on a meeting. From December 2020 to April 2021 "we were involved with her;"
-"any outgoing correspondence had to be signed by the [Director/QP] and she was censoring/editing clinical information in letters ...this wasn't the first time;"

Interview on 9/27/21 with the Director/QP revealed:
-when she became Director/QP, it was her responsibility to co-sign letters of support that come from clinicians to outside providers that

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supported what was in the client record;
-site managers were then trained to sign letters;
-she reported that typically it is a three day turnaround for letters;
-she reported a complaint was filed with her licensing boards;
-she confirmed SAIOP staff requested a letter to be signed for DC#3 and produce the email exchanges between herself and the SAIOP team;
-weekly staffing notes for DC#3 should be in the file;
-she reported that in regard to the letter, if it was an emergency situation "staff could have picked up the phone;"
-she reported that she had no other conversations with SAIOP staff about DC#3 outside of an email exchange;
-She reported being unaware that DC#3 had so many absences and reported the responsibility went back to SAIOP staff;
-facility staff learned of DC#3's death on 4/16/21 and she completed the internal incident report;
-she denied that anything was changed in DC#3's chart during the survey.

Review on 9/17/21 of the job description for Director of Outpatient and Community Services (Director/QP) revealed:
-"The Director of Outpatient and Community Based Services ensures vertical and horizontal communication in a timely manner to achieve client centered and organizational goals ...
The Director has direct responsibility for the oversight of all administrative and clinical functions, as well as interdepartmental coordination of care within assigned clinics and programs;"
-"facilitates communication to internal and external stakeholders;"
-"Directs continuous evaluation of quality clinical

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V 109	Continued From page 8 care provided to consumers ...meets with direct clinical and direct care staff and other departmental teams to discuss and resolve consumer care issues;" Review on 9/8/21, 9/9/21 and 9/16/21 of DC#3's record revealed: -letter for probation was not in the file; This deficiency is cross referenced in to a 10A NCAC 27G .4401 SCOPE (V266) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be	V 112		

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V 112	Continued From page 9 obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to meet the needs of the clients in treatment plans effecting 1 of 1 deceased client (DC#3) and 1 of 1 former client (FC#4). The findings are: Review on 9/8/21 and 9/9/21 of DC#3's Electronic Health Record (EHR) revealed: -Admission Date: 09/21/20; -Discharge Date: 3/25/21; -Date of Death: 4/5/21; -Diagnoses: Post Traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), with panic attacks, Methamphetamine Use Disorder (D/O), moderate, in early remission; Opioid Use D/O, moderate, in early remission; and Cannabis Use D/O, moderate in early remission A. Pre-admission history revealed: -referred to Substance Abuse Intensive Outpatient Program (SAIOP) from federal probation for substance use and mental health with attached contract for payment; -history of inpatient and outpatient treatment for substance use and trauma; -DC#3 had received substance use treatment through the agency in the past;	V 112		

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V 112	Continued From page 10 B. Person Centered Plan (PCP) completed on 12/21/20 with goals to address client's substance use and mental health by attending SAIOP groups, individual therapy, medication management, and use of mobile crisis as needed; -objectives related to substance use goals included: "Client will attend SAIOP from 9:00am-12:15pm Monday, Wednesday, and Friday;" -strategies to achieve this goal included: "substance abuse providing education to client on how to maintain a substance free lifestyle, giving client early intervention strategies to maintain abstinence, providing case management and linkage to resources;" -service and frequency were listed as: "36 Sessions of SAIOP, Monday, Wednesday, and Fridays from 9:00am-12:15pm;" -Objectives related to mental health goals included: "[DC#3] will attend individual counseling as an adjunct to SAIOP services as clinically indicated;" -strategies to support mental health goals were listed as: "Therapist will provide on average, weekly individual/group counseling sessions as clinically indicated that address symptoms of PTSD/GAD;" -service and frequency were listed as: "individual counseling sessions 15-45 minutes in length weekly and/or as clinically indicated". -strategies and service frequency related to treatment goals for DC#3 were not individualized; -Target Date was set for 12/20/2021 and there was no schedule for review prior to that date; -There was no update to the treatment plan to address DC#3's poor attendance, lack of engagement and suspected relapse. C. Service notes revealed:	V 112		

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V 112	Continued From page 11 - 3/25/21: DC#3 "discharged from program - attendance fails to meet requirements for SAIOP Also failed to report for random drug screen on 3-22-21. Removed from group list;" -3-22-21: "arrived late to group (11:00am) Client was staffed and decision made to consider discharge for non-compliance for repeated no shows and late entries to group. Client is not meaningfully engaging in SAIOP. Collateral information reflects that client is actively using substances and falsifying Urine Drug Screens (UDS) since they are not being observed;" -3-22-21: "contact with client to request UDS (5pm). Client returned call to staff (Qualified Professional) at 7:43pm and stated out of town. Was told she was being discharged with recommendation for higher level of care. Client reported need for her mental health issues to be addressed and stabilization. She was encouraged to contact mobile crisis for stabilization which she agreed to do so in near future;" -from 12/21/20 to 3/25/21, DC#3 had three individual therapy sessions: 1/8/21 from 12:00-12:45pm, 2/5/21 from 11:00-11:45am, and 3/1/21 from 9:00-9:30AM for a total of 1.50 hours; -2 of the 3 individual therapy sessions for DC#3 occurred during regular SAIOP group hours (9:00am-12:15pm) ...on 1/8/21, group was only held for 1.5 hours; -12/14/20 and 1/28/21 Comprehensive Clinical Assessment (CCA) updates were completed that made the same recommendations for SAIOP services. Review on 9/8/21, 9/9/21 of DC#3's EHR revealed: -DC#3 did not attend SAIOP on the following dates: -3/19/21, 3/12/21, 3/10/21, 2/22/21, 2/19/21, 2/8/21, 2/3/21, 1/25/21, 1/20/21, 1/18/21,	V 112		

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V 112	Continued From page 12 1/15/21, 1/4/21, 12/28/20, 12/25/20, and 10/26/20. Review on 9/21/21 of (SAIOP) intake policies revealed: -the SAIOP Client Service Agreement and Consent for Services is included in the intake and is signed by clients acknowledging the policies; -"Regular attendance of group sessions is required. I understand that 6 (six) unexcused absences may result in having to restart the program." Review on 9/16/21 of DC#3's EHR revealed: -two drug screens uploaded in the file: 1/25/21 and 2/11/21; -no documentation of staffing or treatment team notes in the file; Interview on 9/15/21 with Former Qualified Professional (QP) #2 revealed: -when asked who was responsible for updating treatment plans, her response was that the SAIOP team did progress notes on the EHR ... -regarding a client needing a higher level of care, "it would be documented in the record." -she reported that she didn't have any in-house training on treatment plans ....she "learned from another clinician and template ...it would have been helpful;" -"every Thursday at 9am we had a treatment team meeting and formal staffing that lasted 90 minutes ...I never missed a note ....I would give them to the clinic manager;" -she reported that the SAIOP team staffed DC#3's treatment all the time; -in regard to SAIOP attendance policy, and clients missing groups she reported that typically facility staff would call clients in, review the plan, and could put them on a contract ...but with probation	V 112		

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V 112	Continued From page 13	V 112		

it was different;
-she reported she had a meeting with DC#3, probation, and Former Therapist #2 about her absences and it should be in the file;
-she learned about DC#3's death from probation on 4/16/21.

Interview on 9/8/21 with the Former Therapist #3 (FT#3) revealed:
-expressed concerns about treatment plans not being individualized, "they are boiler plates;"
-when asked if it was typical to see gaps in service notes with communication with clients, he reported "no, never;"
-expressed concerns about drug screens not being administered;
-Former QP#2 would come in to make the treatment plan;
-stated the note on 3/22/21 reflected the level of crisis being experienced by DC#3 and the need for a higher level of care;
-DC#3's file had been put through a "legal filter" when the survey began on 9/8/21;
-DC#3 was discharged from SAIOP and the team tried to do an inpatient placement at a local hospital.

Interview on 9/15/21 with the Federal Probation Officer revealed;
-DC#3 was on federal probation for conspiracy to manufacture and solicit methamphetamine;
-her date of death was 4/5/21;
-probation could not disclose any further information due to confidentiality;
-communication between probation and the SAIOP program should be found in the SAIOP notes.

Review on 9/15/21 of FC#4's EHR record revealed:

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V 112	Continued From page 14 - Admission date: 10/26/20 - Discharge date: 2/15/21 - Diagnoses: Methamphetamine Use D/O, Severe, Methamphetamine Induced Anxiety D/O, and Unspecified Anxiety D/O -consent for SAIOP services signed on 10/26/20; -Pre-admission history included incarceration history due to substances anxiety and psychological issues exacerbated by substance use, addiction within family system, and medical issues; -Person Centered Plan (PCP) completed on 11/20/20 with goals to address the clients desired substance use and mental health through SAIOP groups, individual therapy, medication management and mobile crisis as needed; -Objectives related to FC#4's substance use included: "Client will attend SAIOP from 9-12:15 Monday, Wednesday, and Friday;" -"Client will schedule and engage in individual therapy to address mental health diagnosis and increase in the severity of anxiety he reports experiencing;" -"Client will prior to completion of treatment episode, develop an aftercare plan with input from staff to address long term recovery needs as determined at time of discharge;" -strategies related to achieving this goal included : "substance abuse provider educating client on how to live and maintain a substance free lifestyle, giving client early intervention strategies to maintain abstinence and teaching client on medical concept of addiction;" -objectives related to his mental health diagnoses included: "Client will attend individual counseling as an adjunct to SAIOP services as needed;" Strategies related to this objective were: "therapist will provide on average weekly/individual/group sessions as clinically indicated that address symptoms of Unspecified	V 112		

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V 112	Continued From page 15 Anxiety D/O;" -service frequency: Individual counseling sessions (15-45 minutes) sessions weekly or as clinically indicated; -from 10/26/20 to 2/15/21 FC#4 had 2 individual therapy sessions out of 5 scheduled that addressed mental health in addition to SAIOP group sessions for a total of 90 minutes; -FC#4 had individual therapy sessions on 12/2/20 and 1/13/21 for 45 minutes each time; -three drug screens uploaded in the file with dates of 11/30/20, 12/28/20, and 2/15/21; -FC#4's treatment plan was not updated to show progress during treatment; -FC#4's strategies and service frequency were the same as DC#3's treatment plan did not address FC#4's Anxiety with lack of attendence in individual counseling; Interview on 9/27/21 with the Director of Outpatient Services West (Director/QP) revealed: -they currently have clinicians providing therapy services via telehealth; -there is wavier currently in place for drug screens, but they can still do them if needed; -when asked if two therapy sessions for the entire SAIOP program was typical she reported "no, not typical, but not impossible". -she reported the SAIOP team determined how often a client is seen individually; -typically, a client would start out with weekly individual sessions and "titrate from there;" -if a client needed a higher level of care it would be documented in the file; -the team had weekly staff meetings and would meet with the client to make that recommendation and do a CCA update; -"when discharging clients, they do an updated CCA, and they can do them without the client present;"	V 112		

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V 112	Continued From page 16 -weekly staffing notes should be in the file and she reported she did not see any in DC#3's file; -"every time someone tries to engage a client and reaches out it should be documented in the EHR;" -in regard to absences from the SAIOP program, she reported it "depended on clinical need and was individualized by county ...our policy and procedure follows the service definition to a T;" -she advised the policy about 6 unexcused absences may result in having to start the program over; -in regard to DC#3 having 14 absences, she reported being unaware of this and that the responsibility would fall back to the SAIOP team to document this and staff the case with appropriate staff; -there should be nothing changed in DC#3's file after 4/16/21 when staff learned of her death, "the file was closed;" -when asked why there were signatures in the file from 4/26/21 from a former site manager, she clarified that he did monthly reports for probation for all 7 counties. This deficiency is cross referenced in to a 10A NCAC 27G .4401 SCOPE (V266) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 266	27G .4401 Sub. Abuse Intensive Outpt - Scope 10A NCAC 27G .4401 SCOPE (a) A substance abuse intensive outpatient program (SAIOP) is one that provides structured individual and group addiction treatment and services that are provided in an outpatient setting designed to assist adults or adolescents with a primary substance-related diagnosis to begin	V 266		

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V 266	Continued From page 17 recovery and learn skills for recovery maintenance. (b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse and other homogenous groups. (c) Each SAIOP shall have a structured program, which includes the following services: (1) individual counseling; (2) group counseling; (3) family counseling; (4) strategies for relapse prevention, which incorporate community and social supports; (5) life skills; (6) crisis contingency planning; (7) disease management; (8) service coordination activities; and (9) biochemical assays to identify recent drug use (e.g. urine drug screens). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide services within the scope of program affecting 1 of 1 former client (FC#4) and 1 of 1 deceased client (DC#3) and failed to coordinate services for 1 of 1 deceased client (DC#3). The findings are: Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record reviews and interviews the	V 266		

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V 266	Continued From page 18 facility failed to ensure implementation of strategies and update documentation of client progress in treatment plans affecting 1 of 1 deceased client (DC#3) and 1 of 1 former client (FC#4). Cross reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record reviews and interviews, 1 of 2 current Qualifed Professionals (QP), (Director/QP) and 3 of 3 former staff, (Former Therapist #2, Former Therapist #3, and Former QP#2 failed to demonstrate knowledge skills and ability required by the population served. The findings are: Cross reference: 10A NCAC 27G .4403 Operations (V268) Based on record reviews and interviews, the facility staff failed to complete discharge plans affecting 1 of 1 deceased client (DC#3) and 1 of 1 former client (FC#4). Interview on 9/17/21 with Qualified Professional #1 (QP#1) revealed: -she was unclear of which agency therapist was currently assigned to the Substance Abuse Intensive Out Patient (SAIOP) program; -SAIOP currently had 2 clients; -she shared QP responsibilities for other programs within the agency; -they held internal team meetings on Thursdays; -she reported that the facility went from having coverage, to needing coverage and was on her third boss since May 2021; -she reported if a client needed a higher level of care, a clinician would do an updated Comprehensive Clinical Assessment (CCA);	V 266		

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Interview on 9/9/21 with Therapist#1 revealed:
-expressed concern that accountability is big with substance use and they were not drug screening clients like they were pre-COVID;

Interview on 9/27/21 with Director/QP revealed:
-Every time facility staff attempt to engage with a client, facility staff document it in the record;
-Staff also sent letters out and have gone to consumer homes to attempt to re-engage clients;
-if there is a reason to believe that a client is in danger, the situation is staffed with mobile crisis, documented in the record, and a CCA update is completed.

Review on 9/8/21, 9/9/21 and 9/16/21 of DC#3's record revealed:
-there was no documented evidence of ongoing communication with probation;
-there was no evidence that any referrals were made for DC#3 to go to inpatient treatment at time of discharge;

Review on 10/01/2021 of Initial Plan of Protection written and signed by the Regional Director on 10/1/21 revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care?
-[The agency] will continue to deliver the same high-quality services that it has always provided and does provide on a daily basis;
To be sure, the above statement and plan below should be interpreted as any concession of violations of any law or applicable rule of ethics. Specifically, [the agency] is not aware of any concerns regarding these issues with any of its current staff. Although [the agency] became aware of some problematic behavior earlier this year, all three employees who were identified

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were terminated. The thorough investigation into that matter did not identify any other [the agency] staff who were out of compliance with either the law, professional ethics, or [the agency's] own operational policies and procedures. As a result, [the agency] is not aware of any clients who are at high risk with respect to [the agency's] services beyond the underlying high risk situations affecting all [the agency] clients as a direct result of their substance use disorders.

Describe your plans to make sure the above happens:
[The agency] will provide refresher training to all staff on protocols for case documentation, identification and reporting of client crisis concerns, and identification and reporting of professional practice concerns. [The agency] will provide refresher guidance to its staff and will continue to work with all management and supervisory level staff to emphasize the importance of existing documentation and reporting protocols.
The following reminders will occur initially through an email notification to all SAIOP staff including supervisors and Directors by Regional Director, on 10/1/2021.

SAIOP staff including supervisors and Directors will be reminded of existing policies, procedures, and standards regarding the initial development of and updating of treatment plans. This includes but is not limited to: [the agency] Policies and Procedures, Clinical Coverage Policy 8A, DHHS Records and Documentation Manuel (APSM 45-2) and rules for MHDDSA Facilities and Services (Administrative Code 27G).

SAIOP Staff including supervisors and Directors will be reminded to follow existing protocols and

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workflow to ensure regular treatment team staffing is occurring. While neither the Clinical Coverage Policy 8A nor Rules for MHDDSA Facilities and Services set forth specific requirements for this to occur, agency protocol requires a treatment team staffing to occur at least monthly. Staff will be reminded of the need for this to occur and to be documented within EHR (electronic health record).

SAIOP Staff including supervisors and Directors will be reminded to follow existing protocols and workflows to ensure discharge planning occurs and that a Discharge Plan is completed. Specifically, as set forth in [the agency] Policy and Procedure, staff will be reminded that discharge planning begins at admission and specific to SAIOP Services, a plan must be completed and included in the clients record. Staff will also be reminded that referrals to services for client as designated in the treatment plan should occur and documentation of such should be included in the client record.

In addition to the above referenced email notification and reminder, Regional Director, Clinical Director, and/or Director of Outpatient Services East, will attend the next scheduled SAIOP Treatment Team Staff Meeting to review the above items.

Furthermore, audits will continue to be conducted by Peer Review Committee, Quality Assurance personnel, Compliance, and/or Clinical Leadership will occur at minimum quarterly. Specifically, those responsible for conducting these audits will be instructed to specifically monitor above areas of concern. When deficiencies are identified, the Director of Compliance, Regional Director, and/or Clinical

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V 266	Continued From page 22 Director will be notified of these findings for subsequent follow-up with Clinical Leadership/staff." Review on 10/04/2021 of Amended Plan of Protection written and signed by the Regional Director on 10/4/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? - [The agency] will continue to deliver the same high-quality services that it has always provided and does provide on a daily basis; To be sure, the above statement and plan below should be interpreted as any concession of violations of any law or applicable rule of ethics. Specifically, [the agency] is not aware of any concerns regarding these issues with any of its current staff. Although [the agency] became aware of some problematic behavior earlier this year, all three employees who were identified were terminated. The thorough investigation into that matter did not identify any other [the agency] staff who were out of compliance with either the law, professional ethics, or [the agency's] own operational policies and procedures. As a result, [the agency] is not aware of any clients who are at high risk with respect to [the agency's] services beyond the underlying high risk situations affecting all [the agency] clients as a direct result of their substance use disorders. Describe your plans to make sure the above happens: 1.[The agency] will provide refresher training to all staff on protocols for case documentation, identification and reporting of client crisis concerns, and identification and reporting of professional practice concerns. This will be accomplished via direct review and training	V 266		

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provided to SAIOP staff during SAIOP Team Meeting scheduled for 10/5/21. This training will be provided by Regional Director/and or Director of Outpatient Services East.

2.Additional refresher training will be assigned to SAIOP staff through the use of our Relias Training System. SAIOP staff will be assigned the below training courses with a due date for completion of 10/5/21. The Director of Compliance and Regional Director will ensure that these trainings are completed by due date and will coordinate Administrative Suspension for any staff who have not completed the training by the due date, to remain in effect until the training is completed.

" SAIOP Service Definition
" Documentation for Treatment Planning
" Ethics for Substance Use Disorder Counselors

3. [The agency] will provide refresher guidance to its SAIOP staff and will continue to work with all management and supervisory level staff to emphasize the importance of existing documentation and reporting protocols. This will be conducted by Regional Director and or Director of Outpatient Services East during the next scheduled SAIOP Team meeting on 10/5/2021. Also, at this time, the above referenced training requirements will also be reviewed. These items reviewed/discussed will be documented in Team Meeting Minutes.

4. The following reminders will occur initially through an email notification to all SAIOP staff including supervisors and Directors by Regional Director, on 10/4/2021. In addition to this email notification and reminder, Regional Director, Clinical Director, and/or Director of Outpatient

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V 266	Continued From page 24 Services East will attend the next scheduled SAIOP Treatment Team Staff Meeting on 10/5/2021 to review these items. " SAIOP staff including supervisors and Directors will be reminded of existing policies, procedures, and standards regarding the initial development of and updating of treatment plans. This includes but is not limited to: [The Agency] Policies and Procedures, Clinical Coverage Policy 8A, DHHS Records and Documentation Manuel (APSM 45-2) and rules for MHDDSA Facilities and Services (Administrative Code 27G). " SAIOP Staff including supervisors and Directors will be reminded to follow existing protocols and workflow to ensure regular treatment team staffing is occurring. While neither the Clinical Coverage Policy 8A nor Rules for MHDDSA Facilities and Services set forth specific requirements for this to occur, agency protocol requires a treatment team staffing to occur at least monthly. Staff will be reminded of the need for this to occur and to be documented within EHR. " SAIOP Staff including supervisors and Directors will be reminded to follow existing protocols and workflow to ensure discharge planning occurs and that a Discharge Plan is completed. Specifically, as set forth in [the agency] Policy and Procedure, staff will be reminded that discharge planning begins at admission and specific to SAIOP Services, a plan must be completed and included in the clients record. Staff will also be reminded that referrals to services for client as designated in the treatment plan should occur and documentation of such should be included in the client record. 5. Furthermore, audits will continue to be conducted by Peer Review Committee, Quality Assurance personnel, Compliance, and/or	V 266		

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Clinical Leadership will occur at minimum quarterly. Specifically, those responsible for conducting these audits will be instructed to specifically monitor above areas of concern. When deficiencies are identified, the Director of Compliance, Regional Director, and/or Clinical Director will be notified of these findings for subsequent follow-up with Clinical Leadership/staff. Specific quality reviews to be conducted on all currently authorized clients in the SAIOP program by 10/8/21 and will be reviewed with applicable SAIOP staff by 10/15/21."

SA Recovery is a Substance Abuse Intensive Outpatient Program that serves clients with moderate to severe level substance use with mental health disorders in an outpatient setting. Treatment includes weekly structured treatment groups, individual sessions, and activities to address and maintain sobriety for clients that have substance use and mental health needs. The facility failed to update treatment plans for FC#4. DC#3 had a history of previous substance abuse treatment, trauma, and mental health issues. The facility did not update or individualize strategies in the treatment plan according to the client's needs or document their attempts to re-engage this client when she became non-compliant with the program. DC#3 did not attend 14 SAIOP sessions. The facility provided 1.5 hours of individual counseling to both FC#4 and DC#3. Additionally, there was no documented evidence that the SAIOP team held internal staffings, although SAIOP team members stated this was their practice. The facility failed to coordinate care for the deceased client by not coordinating with probation and not arranging discharge services, including referring and linking DC#3 to inpatient hospitalization, as per their own

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V 266	Continued From page 26 recommendations and policy. When the probation officer requested a letter regarding current recommendations for DC#3, the facility provided the letter 7 business days later after it was changed and modified by the Director/QP to also include inaccurate information. It was unable to be determined if the record was received in its entirety due to a claim by Former Therapist #3 that DC#3's record had been filtered. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,0000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 266		
V 268	27G .4403 Sub. Abuse Intensive Outpt - Operations 10A NCAC 27G .4403 OPERATIONS (a) A SAIOP shall operate in a setting separate from the client's residence. (b) Each SAIOP shall operate at least three hours per day, at least three days per week with a maximum of two days between offered services. (c) A SAIOP shall provide services a maximum of 19 hours for each client. (d) Each SAIOP shall provide services a minimum of nine hours per week for each client. (e) Group counseling shall be provided each day program services are offered. (f) Each SAIOP shall develop and implement written policies to carry out crisis response for their clients on a face to face and telephonic basis 24 hours a day, seven days a week, which shall include at a minimum the capacity for face to face emergency response within two hours.	V 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL020-084	A. BUILDING: _____ B. WING _____	10/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SA RECOVERY	750 HIGHWAY 64 MURPHY, NC 28906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 268	Continued From page 27 (g) Before discharge, the program shall complete a discharge plan and refer each client who has completed services to the level of treatment or rehabilitation as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to complete discharge plans affecting 1 of 1 deceased client (DC#3) and 1 of 1 former client (FC#4). The findings are: Review on 9/8/21 and 9/9/21 of DC#3 Electronic Health Record (EHR) revealed: -Admission Date: 09/21/20 -Discharge Date: 3/25/21 -there was no documented discharge plan in the file or evidence of referrals. Review on 9/15/21 of FC#4's EHR revealed: -Admission date: 10/26/20 -Discharge date: 2/15/21 -no documented discharge plan in the file despite successful program completion. Review on 9/29/21 of the agency's policy on Substance Abuse Intensive Outpatient Program, effective 9/7/16 revealed: -a "documented discharge plan shall be discussed with the client and included in the record;" -other required documentation included: "Discharge, Aftercare, Transition, or Relapse Prevention Plans;" were to be included in the file. Interview on 9/17/21 with the Qualified Professional #1 (QP#1) revealed:	V 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 268	Continued From page 28 -she stated there is no formal documentation for discharge; -at discharge, a Comprehensive Clinical Assessment update is done and filed in the client record. Interview on 9/27/21 with Director of Outpatient Services revealed: -regarding discharge, "the last thing would be a CCA update." Interview on 9/15/21 with Former QP#2 revealed: -DC#3 needed a higher level of care and wanted to go to a local hospital for inpatient treatment ...she did not like the agency's detoxification option because of past experience; -"transitions were done in orders;" that's why she put in a note to have an updated CCA done for DC#3 at discharge. This deficiency is cross referenced in to a 10A NCAC 27G .4401 SCOPE (V266) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 268		