Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-143	A. BUILDING: _____ B. WING _____	R 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW SEASON MORGANTON	145 WEST PARKER ROAD, SUITE C MORGANTON, NC 28655

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V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on May 23, 2022. The complaint was unsubstantiated (Intake #NC00174166). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. This facility had a census of 161. The survey sample consisted of audits of 7 current clients and 1 deceased client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

06/15/2022

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

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that its written policies and procedures for applicable standards of practice were being implemented. The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals (V109). Based on record reviews and interview, 1 of 2 audited Qualified Professionals (Program Director) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview the facility failed to ensure that staff were trained in Cardiopulmonary Resuscitation (CPR) and First Aid for 2 of 2 audited staff, (Nursing Supervisor and Program Director). Cross Reference: 10A NCAC 27G .3603 Staff (V235). Based on record review and interview, the facility failed to maintain a minimum of one counselor to 50 clients. Cross Reference: 10A NCAC 27G .3604 Operations (V237). Based on record reviews, and interviews, the facility failed to comply with The Substance Abuse and Mental Health Services Administration (SAMSHSA) regulations. Review on 5/12/22 of the facility's policy and procedure manual regarding "Patient Benzodiazepine Use" revealed:	V 105	The medical director will be onsite at the center, at a minimum weekly, effective immediately. Should such medical director not be able to provide onsite supervision to the Nurse Practitioner weekly, one will be obtained to resume his role in Morganton as the medical director within 23 days contingent upon receiving qualified applicants who meet the required background stipulations as set forth by SAMHSA. In the interim, the Medical Director will also make weekly contact with the Nurse Practitioner. Staff will be provided with CPR training onsite. At all times while the center is open, someone who is certified in CPR will be in the facility. CPR training is currently scheduled for 06/21/2022. New Season Talent Acquisition Team along with New Season Morganton's Program Director, Regional Director and Senior Vice President of Clinical Operations, will work simultaneously to recruit and employee a certified or licensed counselor for New Season Morganton Treatment Center to fulfill the requirements for counselor to patient ratio of no more than 50:1. The overage of 9 patients was be moved to an alternative counselor that has been provided for Morganton which makes us within the 50:1 ratio.	

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V 105	Continued From page 3 -"It is the policy of Metro Treatment of North Carolina, LP that patients using benzodiazepine medications will be evaluated and assessed for their ongoing appropriateness for treatment or continued treatment in our Opiate Treatment Programs (OTP)...; -3. If the urine drug screen in question is a second positive urine drug screen reflecting illicit drug use, the patient will be staffed in a treatment team staffing and indicated the patient will be required to attend a special care program appropriate to meet patient's clinical needs; -4. The elements of special care program will include the following: bi-weekly evaluation and assessment by the treatment team (Medical Director, Program Director, Treatment Services Coordinator, Counselors, and Nurses ...); c. all treatment team interventions shall be appropriately documented in the patient's record ....examples of treatment team interventions include: -(e) ....as long as the patient is making adequate progress addressing their concurrent benzodiazepine use, the patient can continue their treatment at the OTP;" -Once the patient has become involved with the special care program, they patient will be given up to 120 days to demonstrate that they have successfully undergone a medical withdrawal from the substance... or ...demonstrated significant clinical progress in their reduction of use; -"if the treatment team determines patient is no longer benefiting from treatment or demonstrating increased risk ...patient will be referred to ...more appropriate and higher level of substance abuse treatment ..." Continued review on 5/12/22 of facility's policy	V 105	Staff will immediately follow policy for involuntary discharge as stated on page 388-389 in the New Season NC P&P manual (attached) that states: The following steps pertain to the involuntary discharge process: 1. Counselors/case managers will meet with the Program Director to review all prior efforts on the patient's behalf and to explore alternative options. 2. The Program Director speaks with the Regional Director regarding the program's intent to discharge a patient. The Regional Director provides guidance as to further actions. Staff members should not discuss involuntary discharges with the Medical Director before notifying the Regional Director that such action is contemplated. 3. Should involuntary discharge be warranted, the Program Director, under the direction of the Regional Director, makes recommendation to the Medical Director. 4. Should involuntary discharge be warranted, the Medical Director will issue his or her determinations and subsequent medically supervised withdrawal protocol. 5. Counselor meets with patient and informs the patient of action selected. Patient may receive assistance, if he or she so desires, with transfer to another center in lieu of a medically supervised withdrawal procedure at the center. 6. Counselor closes out case as a transfer (as applicable) or, the nurse begins medically supervised withdrawal protocol. 7. Counselor closes out patient record following medically supervised withdrawal.	

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V 105	Continued From page 4 and procedure manual regarding "Treatment Retention of Patients with Continuous Positive Drug Screens" revealed: -"Metro Treatment of North Carolina, LP recognizes that some patients may continue to use illicit drugs during treatment and, that such use will be detected through urine drug screenings ...it is the policy of Metro Treatment of North Carolina, LP to use clinically appropriate interventions in an attempt to motivate the patient to discontinue drug use: -2. Counselors will consider each of the following for implementation and if the following are not implemented there will be clinical documentation as to why: (a-j) a. Withhold take home privileges until urinalysis are free of illicit drugs; b. Place patient on 90 day probation or rescind take home privileges by reduction in phase; c. Document in client's chart, if appropriate, the patients written rationale for continuing treatment; d. Increase counseling contacts; e. Create referral to an outside agency ...such as ...Narcotics Anonymous, Community Mental Health Center ...Personal Physician; f. Consider effecting counselor change; g. Transfer to inpatient ... intensive outpatient ...; h. Increase frequency of urine drug screens; i. Consider Involuntary Medical Supervised Withdrawal. This is not to be based solely on result of a urine drug screen, but with the input from counselors, nurses, Program Director and Medical Director;" j. Seek supervision from the Program Director, Medical Director, and peers to facilitate learning and identify personal strategies...Once the Program Director and Medical Director's medical determination are issued, treatment shall either proceed toward discharge or continuation of	V 105		

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V 105	Continued From page 5 treatment per team direction." Review on 5/16/22 of Client#6's record revealed: Date of Admission: 4/17/19; Diagnosis: Opioid Use Disorder, Severe; Admission History and Physical dated 4/17/19 revealed: prior methadone treatment and poly-substance use; Admission/Transfer Dose: 70 milligrams (mg) of Methadone; Age: 32 Further review on 5/16/22 of Client#6's record revealed: 12/28/21-3/28/22 Treatment Plan Summary indicated that Client will meet with counselor-bi-weekly regarding Benzodiazepine use due to Special Care requirements with provider and provide bi-weekly Urine Drug Screens (UDS) for Benzodiazepine (BZO) use; -documentation of UDS from 11/29/21 to 5/6/22; -15 drug screen results from the following dates: 11/29/21, 12/14/21, 12/27/21, 1/6/22, 1/25/22, 2/8/22, 2/25/22, 3/7/22, 3/22/22, 4/1/22, 4/8/22, 4/15/22, 4/22/22, 4/29/22, and 5/6/22; -All 15 urine drug screens for Client#6 were positive for Benzodiazepines, Methamphetamine and Marijuana (THC); -14 of 15 drug screens were also positive for Fentanyl; -5 of 15 drug screens were also positive for opiates in addition to the above illicit substances; -3/7/22 drug screen was positive for Barbiturates, Benzodiazepine, Alcohol, Methamphetamine, Tetrahydrocannabinol (THC), and Fentanyl. Review on 5/16/22 of Client#6's Counseling/Case Notes from 1/15/22 to 5/11/22 revealed: -2/2/22 Clinical Staffing, treatment team met, provider declined a dose increase, no other	V 105		

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V 105	Continued From page 6 recommendations listed; -2/17/22 "Nursing/Medical Education (Med/Ed): patient admits missing mental health appointment and has new appointment with a physician in March ...patient is encouraged to decrease his BZO use and educated on safety concerns with recent increase in BZO levels in UDS ...request for increase will be re-evaluated at a later time;" -3/17/22 "Nursing Med/Ed: Patient reports he has tried to decrease his BZO usage and has attended an Narcotics Anonymous (NA) meeting ...Discussed cardiac risks, aware of danger including death of illicit use ....Discussed most recent UDS which includes Alcohol, Methadone, Fentanyl, Benzodiazepine (BZO), Barbiturates, and Marijuana (THC) ...is scheduled for another screen this week;" -4/01/22 Random UDS; -4/07/22 "UDS reviewed by Nurse Practitioner (NP), positive for continued illicit substances ...counselor to address continued THC, Opiates, and BZO's;" -4/08/22 Random UDS; -4/14/22 "UDS reviewed by NP, positive for continued illicit substances ...counselor to address ... Opiates, Meth/Amphetamines, BZO's and THC;" -4/15/22 Random UDS; -4/21/22-"UDS reviewed by NP, positive for continued illicit substances ...counselor to address regarding continued Opiates, BZO's, and THC ...this is special care patient;" -4/22/22-Random UDS; -4/28/22-"UDS reviewed by NP ...Positive for continued illicit substances ...counselor to address continued Opiates, THC, BZO's and Meth/Amphetamines;" -4/29/22-Random UDS; -5/2/22-"Nursing Med/Ed: recommended to see NP by counselor, patient got a new job and	V 105		

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V 105	Continued From page 7 insurance going in to effect today ...he is confident that his Benzodiazepine (BZO) and Fentanyl levels should begin start decreasing and asks for dose increase ...Reviewed most recent UDS as recent as 2 weeks ago and BZO levels have actually increased and Fentanyl levels remain ...Also most recent UDS on 4/15/22 included positive for Oxycodone and Opiates ...whereas 4/1/22 UDS was negative for Oxycodone and Opiates ...discussed risks ...aware of danger including death ...;" -5/6/22-Random UDS; -5/10/22-"NP reviewed UDS from 4/29/22, positive for continued illicit substance ...Counselor to address continued Opiates, THC and BZO's;" -there was a lack of documented evidence in Client #6's record of why he was not considered for involuntary medically supervised withdrawal program per policy, transferred to another facility or higher level of care, or that consultation with the current medical director (MD) occurred despite Client #6's continuous positive drug screens with Benzodiazepines since November of 2021. Interview on 5/17/22 with Client#6 revealed: -he had received treatment at a sister facility and was "kicked out," transferred to another program and then came to this facility; -used opiates; "Heroin, Oxycodone, and Fentanyl ...and Benzodiazepines (Benzos);" -was on the special care program because of the "Benzos" and has weekly drug screens ..."been on the special care program quite a bit;" -his counselor reviews his drug screen results; -he was referred for additional mental health services but missed two appointments, ... " I forgot;" -he'd "seen the nurse practitioner 3-4 times	V 105		

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V 105	Continued From page 8 recently ... not sure of her name." Interview on 5/12/22 with the Nursing Supervisor revealed: -"Benzos especially are dangerous and the opiates on top of it is increased risk for overdose;" -When asked about continued client positive UDS, "2 or more positive screens for Benzos is special care program;" -"if continually testing positive ... possibly Medically Supervised Withdrawal (MSW) program;" -"MSW is decreasing the dose because the safety benefits of treatment do not outweigh the risks ... if we do that and it has to be approved by the treatment team, Program Director, Regional Director and Senior Vice President ...the Medical Director can recommend it;" -"It's mainly Benzo use for the MSW program ...but we also look at Opiates, Fentanyl and Cocaine because there is some risk as well ...but we don't necessarily treat that ...we can refer to outpatient or inpatient services for detoxification." Interviews from 5/11/22 to 5/23/22 with the Program Director revealed: -"20% of the clients at the facility probably look like [Client #6];" -there was only one client from the facility that was referred to the Medically Supervised Withdrawal (MSW) program within the last year: -"Benzos are the only one from our company standpoint;" -He was unaware of Client#6's continued positive screens for Benzodiazepines from November 2021 and why he was not referred to MSW program ..."he would have to check with the counselor;" -" ...if we determine the safety of the patient is at	V 105		

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V 105	Continued From page 9 risk, we would take it to the [Corporate Medical Director] and we would refer to another facility;" -he advised that the current Medical Director would be part of this decision, but he travels a lot out of the country ... so we would use the [Corporate Medical Director]." Review on 5/18/22 of the Corporate Medical Director's Medical Licensure: -The Corporate Medical Director is licensed in Florida; -There was no evidence that the Corporate Medical Director is licensed to provide services in North Carolina. Interview on 5/13/22 and 5/18/22 with the Nurse Practitioner (NP) revealed: -"Benzo's and Alcohol are very concerning factors in their safety ...for overdose risk;" -If clients have two positive illicit Benzodiazepine screens, then they go on special care program, and have 120 days to show improvement; -During this time period, clients are educated, and the facility monitors their Urine Drug Screens (UDS); -Clients may be referred to a mental health professional during this time but can refuse; -After 120 days, clients could go into Medically Supervised Withdrawal (MSW) and could potentially decrease medications; -Clients' Methadone doses during this time are monitored for risk of overdose; -When asked if there is a safe methadone dose with Benzodiazepine she reported: she tries not to increase the dosage beyond a certain amount for Methadone with Benzodiazepine use ..."there's a range ...she's spoken with Medical Director (MD) about it;" -Her collaborating physician, the MD is based out of a sister facility ...and speaks with him by phone	V 105		

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V 105	Continued From page 10 call or text; -The MD "does not come to this facility that she is aware of." Interview on 5/12/22 with the Regional Director revealed: -There's different types of MSW; voluntary taper and Administrative MSW; -Administrative MSW, "somebody comes in ...continues to use ...and offer a higher level of care ...depending on the situation, we may do a reduction to safe level at medical team discretion;" -after second positive Benzo screen, the facility may start referrals to other mental health programs; -"it takes a lot to get someone administratively discharged ...only if high levels ...and if we feel like we have provided all that we can and I would be there to give approval to give MSW ... the Medical Director or Nurse Practitioner would need to be consulted." Interview on 5/19/22 with the Medical Director (MD) revealed: -he was unfamiliar with Client #6's treatment course, "I haven't been there in over a year;" -he did not have access to client files from the facility; -the danger of being on illicit substances in addition to Methadone, "you must weigh the risk ...if you reduce Methadone, they are going to get Fentanyl ... you put them in special care where they are seen weekly;" -"with continued repeated testing positive for illicits ...you have to figure out co-morbidity factors and other factors getting in the way" -"you can't be fully treated and get Fentanyl and add other things ....if you can't clean up in about 6-12 weeks ...then it makes it difficult;"	V 105		

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V 105	Continued From page 11 -"if you are going to wean a patient out and they have no inclination to stop and keep using, then they are at risk of dying;" -"Corporate has told him that if you take someone off and they go out and use and they die, you can still be liable ...it's a double edged sword;" -he has referred very few clients to MSW program because the concern is that the client will just stop coming; Review on 5/19/22 of the initial Plan of Protection signed by the Regional Director on 5/19/22 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "New Season Morganton Treatment Center has provided and will continue to ensure compliance with official exemption waiver for a Nurse Practitioner that was approved December 18, 2020 and is valid until September 30, 2022 The supervising physician will be onsite at the center, at a minimum weekly, effective immediately. Should such supervising physician not be able to provide onsite supervision to the Nurse Practitioner weekly, one will be obtained to resume his role in Morganton as the supervising physician within 23 days contingent upon receiving qualified applicants who meet the required background stipulations as set forth by SAMHSA. Attached you will find certification for [Licensed Practical Nurse], who had onsite CPR training that he obtained from the American Heart Association that is good through 7/2022. Center staff will be provided with onsite CPR certification training within 23 days of this plan and ongoing, to ensure we are in compliance with the regulation set forth for North Carolina. Attached	V 105		

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V 105	Continued From page 12 you will find the approval from the State Opioid Treatment Authority to continue to complete the CPR training online as that was the direction we went with at the time once confirmed. New Season Talent Acquisition Team along with New Season Morganton Program Director, Regional Director and Senior Vice President of Clinical Operations, will work simultaneously to recruit and employee a certified or licensed counselor for New Season Morganton Treatment Center to fulfill the requirements for counselor to patient ratio of no more than 50:1. Effective today, the overage of 9 patients will be moved to alternative counselor that has been provided for Morganton which will make us within the 50:1 ratio. Describe your plans to make sure the above happens -On or before September 1, 2022 the Program Sponsor will request a new waiver approval for Metro Treatment of North Carolina, LP (Licensee) to allow mid-level practitioners to make decisions for opioid treatment medications. -Upon closing of the exit interview, the Regional Director will follow up with the supervising physician to discuss that outcome and plan of protection put in place on this date. At that time, it will be determined the future onsite schedule for the supervising physician followed by immediate implementation. -Date for CPR training to be determined pending a return call from [CPR training program] to schedule based on their facility availability. Should no classes be available within 23 days, the Regional Director will contact an alternative source in the area to provide the training onsite." Review on 5/19/22 of the revised Plan of	V 105		

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V 105	Continued From page 13 Protection forwarded by the Program Director on 5/19/22 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "New Season Morganton Treatment Center has provided and will continue to ensure compliance with the official exemption waiver approval for a Nurse Practitioner that was approved on December 18, 2020 and is valid until September 30, 2022. The medical director will be onsite at the center, at a minimum weekly, effective immediately. Should such medical director not be able to provide onsite supervision to the Nurse Practitioner weekly, one will be obtained to resume his role in Morganton as the medical director within 23 days contingent upon receiving qualified applicants who meet the required background stipulations as set forth by SAMHSA. Attached you will find the certification for [Licensed Practical Nurse] who had onsite CPR training that he obtained from the American Heart Association that is good through 7/2022. Center staff will be provided with onsite CPR certification training within 23 days of this plan and ongoing, to ensure we are in compliance with the regulation set forth for North Carolina. Attached you will find the approval from the State Opioid Treatment Authority to continue to complete the CPR training online as that was the direction we went at the time once confirmed. New Season Talent Acquisition Team along with New Season Morganton Program Director, Regional Director and Senior Vice President of Clinical Operations, will work simultaneously to recruit and employee a certified or licensed	V 105		

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V 105	Continued From page 14 counselor for New Season Morganton Treatment Center to fulfill the requirements for counselor to patient ratio of no more than 50:1. Effective today, the overage of 9 patients will be moved to an alternative counselor that has been provided for Morganton which will make us within the 50:1 ratio. Staff will immediately follow policy for involuntary discharge as stated on page 388-389 in the New Season North Carolina Policy & Procedure manual (attached) that states: The following steps pertain to the involuntary discharge process: 1. Counselors/case managers will meet with the Program Director to review all prior efforts on the patient's behalf and to expiore alternative options. 2. The Program Director speaks with the Regional Director regarding the program's intent to discharge a patient. The Regional Director provides guidance as to further actions. Staff members should not discuss involuntary discharges with the Medical Director before notifying the Regional Director that such action is contemplated. 3. Should involuntary discharge be warranted, the Program Director, under the direction of the Regional Director, makes recommendation to the Medical Director. 4. Should involuntary discharge be warranted; the Medical Director will issue his or her determinations and subsequent medically supervised withdrawal protocol. 5. Counselor meets with patient and informs the patient of action selected. Patient may receive assistance, if he or she so desires, with transfer to another center in lieu of a medically supervised withdrawal procedure at the center. 6. Counselor closes out case as a transfer (as	V 105		

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V 105	Continued From page 15 applicable) or, the nurse begins medically supervised withdrawal protocol. 7. Counselor closes out patient record following medically supervised withdrawal. Describe your plans to make sure the above happens. - On or before September 1, 2022, the Program Sponsor will request a new waiver approval for Metro Treatment of North Carolina, LP to allow mid-level medical practitioners to make decisions for opioid treatment medications. -Upon closing of the exit interview, the Regional Director (RD) will follow up with the medical director to discuss that outcome and plan of protection put in place on this date. At that time, it will be determined the future onsite schedule for the medical director followed by immediate implementation. - Date for CPR training to be determined pending a return call from [CPR Training Program] to schedule based on their facility availability. Should no classes be available within 23 days, the Regional Director will contact an alternative source in the area to provide the training onsite. -RD will provide training to all centers in NC to cover the involuntary discharge policy (attached) to ensure the proper steps are completed in order on a daily basis as it pertains to each individual patient." New Season Morganton is an outpatient facility licensed to serve clients diagnosed with Opioid Dependence. The Medical Director had not been on site at the facility for over one year and did not have access to any of the client records. A Nurse Practitioner was performing intake admission assessments/physicals and determining Methadone doses for a current census of 161	V 105		

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V 105	Continued From page 16 clients. There was no evidence of collaboration between the Medical Director and Nurse Practitioner since 9/1/2021. The Nursing Supervisor, Program Director, Nurse Practitioner and Medical Director stated that clients taking Methadone and benzodiazepines were at a high risk for overdose. Client #6 was prescribed a daily dose of 70 milligrams of Methadone. Client #6 tested positive for benzodiazepines, methamphetamine and marijuana on his past fifteen urine drug screens (UDS). Client #6 also tested positive for fentanyl on fourteen of those past UDS. There was no evidence of consultation with the Medical Director regarding Client #6. There was no evidence that Client #6 was considered for a Medically Supervised Withdrawal (MSW) program as indicated in facility policy. Furthermore, only one staff member at the facility received hands on skills practice for cardiopulmonary resuscitation (CPR) and that one staff member was not always present when clients were at the facility. Additionally, the facility did not maintain ratio requirements of having one counselor per every 50 clients. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 105		
V 108	27G .0202 (F-i) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS	V 108		

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V 108	Continued From page 17 (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff were trained in Cardiopulmonary Resuscitation (CPR) for 2 of 2 audited staff, (Nursing Supervisor and Program	V 108		

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V 108	Continued From page 18 Director). The findings are: Review on 5/11/22 of Program Director's personnel record revealed: -hire date: 2/10/20; -no documentation of successful completion of CPR training that included a hands-on component. Review on 5/11/22 of Nursing Supervisor personnel record revealed: -hire date: 12/1/19; -no documentation of successful completion of CPR training that included a hands-on component. Interview on 5/12/22 with Nursing Supervisor revealed: -Corporate made the decision for online training. Interview on 5/13/22 with Nurse Practitioner revealed: -CPR training was completed online. Interview from 5/11/22 to 5/23/22 with Program Director revealed: -the program the facility used for CPR training only had an online component; -the facility could not find anyone to train hands-on due to COVID; -"everyone" at the facility was reported to be trained online. -he understood that there needed to be a hands-on component. This deficiency is crossed in to 10A NCAC 27G .0201 Governing Body Policies for Type A1 rule violation and must be corrected within 23 days.	V 108		

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V 109	Continued From page 19	V 109		
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 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.	V 109		

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V 109	Continued From page 20 This Rule is not met as evidenced by: Based on record reviews and interview, 1 of 2 audited Qualified Professionals (Program Director) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 5/11/22 of the Program Director's Personnel Record revealed: -Date of Hire: 2/10/20. -Title/Position: Program Director. -Certified Substance Abuse Counselor (CSAC). Review on 5/24/22 of the Program Director's Job Description revealed: -"Ensure compliance with all local, state, federal and [owner] rules, regulations and policies ..." -" ...Monitor all clinic staff and contract labor in the performance of their duties and responsibilities ..." -" ...Ensure appropriate staff levels of qualified personnel are maintained in accordance with local, state, and federal regulations and [corporate management] policies ..." -" ...Ensures proper training and development for all clinic staff and contract labor ..." The following are examples of how the Program Director failed to demonstrate competency: -Failed to ensure there was a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients. Refer to V235 for evidence of non-compliance with staffing ratios. -Failed to ensure at least one staff member with	V 109		

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V 109	Continued From page 21 current certification from a credentialed cardiopulmonary resuscitation program was available in the facility at all times when clients were present. Refer to V108 for evidence of non-compliance with personnel requirements. -Failed to ensure the Medical Director (MD) was present at the program a sufficient number of hours to assure regulatory compliance. Refer to V237 for evidence the Program Director acknowledged the MD's lack of availability. Interview on 5/18/22 with the Program Director revealed: -He was responsible for supervising staff and providing facility oversight. This deficiency is cross referenced into 10A NCAC 27G.0201 Governing Body Policies for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications	V 235		

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V 235	Continued From page 22 to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a minimum of one counselor to 50 clients. The findings are: Review on 5-11-22 of Client and Staff Census Sheet revealed: -Completed by the Program Director (PD). -Current census was 161. -Only 3 counselors were employed by the facility. -No former staff in the past 3 months were qualified as therapists. Interview on 5-11-22 with the PD revealed: -"Only have 3 counselors." -"I do not cover the overflow." -"We are aware that we are over census." -When asked why he did not cover the overflow as he is licensed, the PD responded, "That is per our corporate." -The last therapist to leave was in December 2021. -Have been out of ratio since December 2021.	V 235		

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V 235	Continued From page 23 This deficiency is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 rule violation and must be corrected within 23 days.	V 235		
V 237	27G .3604 (A-D) Outpt. Opiod - Operations 10A NCAC 27G .3604 OPERATIONS (a) Hours. Each facility shall operate at least six days per week, 12 months per year. Daily, weekend and holiday medication dispensing hours shall be scheduled to meet the needs of the client. (b) Compliance with The Substance Abuse and Mental Health Services Administration (SAMHSA) or The Center for Substance Abuse Treatment (CSAT) Regulations. Each facility shall be certified by a private non-profit entity or a State agency, that has been approved by the SAMHSA of the United State Department of Health and Human Services and shall be in compliance with all SAMHSA Opioid Drugs in Maintenance and Detoxification Treatment of Opioid Addiction regulations in 42 CFR Part 8, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the CSAT, SAMHSA, Rockwall II, 5600 Fishers Lane, Rockville, Maryland 20857 at no cost. (c) Compliance With DEA Regulations. Each facility shall be currently registered with the Federal Drug Enforcement Administration and shall be in compliance with all Drug Enforcement Administration regulations pertaining to opioid treatment programs codified in 21 C.F.R., Food and Drugs, Part 1300 to end, which are incorporated by reference to include subsequent amendments and editions. These regulations are	V 237		

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V 237	Continued From page 24 available from the United States Government Printing Office, Washington, D.C. 20402 at the published rate. (d) Compliance With State Authority Regulations. Each facility shall be approved by the North Carolina State Authority for Opioid Treatment, DMH/DD/SAS, which is the person designated by the Secretary of Health and Human Services to exercise the responsibility and authority within the state for governing the treatment of addiction with an opioid drug, including program approval, for monitoring compliance with the regulations related to scope, staff, and operations, and for monitoring compliance with Section 1923 of P.L. 102-321. The referenced material may be obtained from the Substance Abuse Services Section of DMH/DD/SAS. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to comply with The Substance Abuse and Mental Health Services Administration (SAMHSA) regulations. The findings are: Review on 5-13-22 and 5-19-22 of SAMHSA regulations 42 CFR (Code of Federal Regulations) Part 8.12 Federal Guidelines for Opioid Treatment Programs (OTP) revealed: -" ...The medical director shall assume responsibility for administering all medical services performed by the OTP. In addition, the medical director shall be responsible for ensuring that the OTP complies with all applicable Federal, State, and local laws and regulations." -"The medical director is responsible for	V 237		

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V 237	Continued From page 25 monitoring and supervising all medical and nursing services provided by the OTP ..." -" ...The medical director should be present at the program a sufficient number of hours to assure regulatory compliance and carry out those duties specifically assigned to the medical director by regulation ..." Review on 5-12-22 and 5-18-22 of the MD Consulting Agreement revealed: -Electronically signed by the MD on 8-20-20. -" ...shall provide Medical Director services, a minimum 3 hours/maximum of 10 hours each week ..." -"Duties of Consultant ...(d) availability to staff for emergency management of patient care ...(f) Training of nursing staff ...(i) other duties as reasonably requested by Program Director of CLINIC and as set forth in the rules and regulations for medically-monitored treatment programs/facilities in the State in which the CLINIC operates ..." -"12. Compliance with Applicable Laws ...CONSULTANT agrees to comply with all applicable federal, state, and local laws ..." Review on 5-17-22 of SUPERVISING PHYSICIAN COLLABORATION documents revealed: -Collaboration notes for the following dates were provided and reviewed: 4-30-21, 6-7-21, 7-6-21, 9-1-21. -No evidence of any further collaboration after 9-1-21 between the NP and MD. Review on 5-11-22 and 5-12-22 of the facility's Electronic Records revealed: -No documentation of any services provided by the Medical Director (MD) to the audited clients. -No documentation of collaboration/supervision	V 237		

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V 237	Continued From page 26 between MD and Nurse Practitioner (NP) regarding the audited clients. Review on 5/16/22 of Client #6's record revealed: Date of Admission: 4/17/19; Diagnosis: Opioid Use Disorder, Severe; -15 consecutive drug screens that were positive for illicit substances which included; Benzodiazepines, Methamphetamine, Barbiturates, Alcohol, and Fentanyl. -No evidence of any documents having been reviewed by the Medical Director. Interview on 5-12-22 with the Nurse Manager revealed: -Had not seen the MD in over a year and unaware of the last time he had been on-site. Interview on 5-13-22 with the Nurse Practitioner (NP) revealed: -Only see the MD in the sister facility clinic, has never seen the MD in the New Season Morganton clinic. -The MD does not come to the facility. -She would contact a physician at a sister facility if the MD was not available. -The MD was out of the country several times a year and she texted him through an internet messaging platform. -There have been times when the MD had not responded " ...as timely as I need." -In an emergency crisis situation, if the MD was not available would contact another physician that works for the company and/or the corporate MD in another state. -Had concerns about the MD not being on-site. Interview on 5-12-22 and 5-18-22 with the Program Director (PD) revealed: -Documentation of services provided by the MD	V 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-143	A. BUILDING: _____ B. WING _____	R 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW SEASON MORGANTON	145 WEST PARKER ROAD, SUITE C MORGANTON, NC 28655

(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 237	Continued From page 27 would be online with Human Resources. -"[Electronic Record] would be where it shows he provided any service." -Unable to locate any documentation/notes that the MD provided services to the audited clients. -Stated that 20% of the clients at the facility would be similar to the situation of Client #6. -There had only been one client referred to the Medically Supervised Withdrawal program within the past year. -There was no documentation of collaboration between the former NP and recent documentation for the current NP. -He was not sure the last time the MD was on site at the facility. -The MD works in a hospital and is hard to reach. -"I would say he is here every 6 months. I don't always know." -The MD would respond within 24 hours if there were an immediate crisis. -When PD was asked if had contact with the MD to confirm an interview time, the PD stated that he sent a text to the MD on 5-17-22 at approximately 2 pm and did not receive a response until 7:00 am on 5-18-22. The MD is not available until 5-19-22 due to a full schedule at his private practice and has only 5 minutes between patients. Interview on 5-19-22 with the Medical Director revealed: -When the former NP was hired (spring of 2021), he stopped going to New Season Morganton. -The former NP came to a sister facility to shadow. -Was the MD for New Season Morganton and two sister facilities and only went on-site to one of the three facilities. -He stopped going to New Season Morganton because of time limits.	V 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW SEASON MORGANTON	145 WEST PARKER ROAD, SUITE C MORGANTON, NC 28655

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V 237	Continued From page 28 -"The last time I was in [New Season Morganton] ...I can't give you an exact date ...I haven't been there in over a year ...I don't physically go in there to see them." -Had not provided any training to staff. -"Not sure it would be appropriate for a patient to sit and wait for me if there were a medical emergency." -"There was one time [NP] was not aware I had traveled, and I could not get back in touch with her." -Acknowledged that he did not have access to client charts. Relied on history and clinical profile being provided by the NP. -He was unaware of Client #6 and of the specifics related to his treatment. -When asked how he ensured the clinic is operating safely, "Without going there physically, it is difficult ...Without being there and looking through charts, it is difficult to do anything short of that. The need to just go there I don't know maybe once a month or twice a month and arrange with more difficult patients and just go from there. And handle the more difficult patients. It is not the same over the phone and having access to the full record." This deficiency is cross referenced into 10A NCAC 27G .0201 Governing Body Policies (V105) for a Type A1 rule violation and must be corrected within 23 days.	V 237		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 13, 2022

Tabitha Goodpasture, Regional Director
Metro Treatment of North Carolina, LP
2500 Maitland Center Pkwy, Ste 250
Maitland, FL 32751

Re: Annual, Complaint and Follow Up Survey completed May 23, 2022
New Season Morganton 145 West Parker Road, Suite C, Morganton, NC 28655
MHL # 012-143
E-mail Address: Tabitha.goodpasture@cmglp.com
(Intake #NC00174166)

Dear Ms. Goodpasture:

Thank you for the cooperation and courtesy extended during the Annual, Complaint and Follow Up survey completed May 23, 2022. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

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

Type of Deficiencies Found

- Type A1 rule violations are cited for 10A NCAC 27G.0202 Personnel Requirements (V108), 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27G.3603 Staff (V235), 10A NCAC 27G.3604 Operations (V237) crossed into 10A NCAC 27G.0201 Governing Body Policies (V105).

Time Frames for Compliance

- Type A1 violations and all cross referenced citations must be ***corrected*** within 23 days from the exit date of the survey, which is June 15, 2022. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violations by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Metro Treatment of North Carolina, LP for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

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

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

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

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 336-247-1723.

Sincerely,

Maria Smith

Maria Smith
Nurse Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
Smith Worth, SOTA Director
Pam Pridgen, Administrative Supervisor