STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-962	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO TREATMENT OF NC, LP DBA NEW SE/	3911 NEW BERN AVENUE, UNIT A RALEIGH, NC 27610

(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 000	INITIAL COMMENTS An Annual Survey was completed on July 14, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. This facility has a current census of 101. The survey sample consisted of audits of 10 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118		

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V 118	Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assure medication was administered as written by the physician for one of ten audited clients (#1105). The facility also failed to assure one of two audited staff (Licensed Practical Nurse (LPN)) who dispensed medications demonstrated skills and competency with medication administration for ten of ten audited clients (#1195, #1302, #1204, #1102, #1167, #1379, #1104, #1110, #1274 and #1105). The findings are: I. Examples of lack of competency by LPN which yielded inaccurate dosing amounts for clients. A. Example of LPN Not calibrating machine daily. Review on 7/13/22 of the facility's Use of the Graduated Cylinder for Pump Calibration policy revealed: - "It is the policy of Metro Treatment of North Carolina, LP that all clinical pharmacy personnel who have been trained and are approved to dispense medication utilizing either the integrated pump system and the associated software, or with provided hand-pumps in power outage situations, will use graduated volumetric cylinders for the calibration purposes of validating,	V 118		

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V 118	Continued From page 2 dispensed amounts of liquid concentrated medication." Review on 7/12/22 of the facility's LPN's personnel record revealed: - Hired: 2/16/22 - Credentials: Active until 9/30/22 - Nursing training Matrix dated 3/16/22 trainings that included the following for Week 2 Opening the Pharmacy (Beginning of the day) Pump Maintenance Dispensing during Power Outage Review on 7/13/22 of the facility's process for the "beginning of the day- opening the pharmacy" form revealed: - "Step Four: Set Up Pump Empty the Line Prime the line with Methadone Calibrate the Pump..." Review on 7/13/22 of the facility's May- July 2022 calibrations report (holidays and Sundays were not included in this data) revealed: - May: No calibration data 9 out of 31 days. - June: No calibration data 17 out of 30 days - July: No calibration data 5 out of 13 days Interview on 7/12/22 the LPN stated: - Facility was closed on Sundays and holidays. - Calibrations were conducted hourly on the Methadone Dispensary Machine Pump (MDMP). Interview on 7/13/22 the Registered Nurse (RN) Supervisor stated: - Prior to 7/12/22, she was unaware calibrations of the MDMP were not completed daily. B. Example of clients not receiving accurate	V 118		

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V 118	Continued From page 3 dosages of medication 1. Review on 7/12/22 of client #1195's record revealed: - Admitted: 3/5/21 - Diagnosis: Opioid Use Disorder - Physician's order dated 7/12/22 listed Methadone 100 milligram (mg) - Individual dosing log dated 7/12/22 noted 100 mg of Methadone administered. 2. Review on 7/12/22 of client #1302's record revealed: - Admitted: 11/16/21 - Diagnosis: Opioid Use Disorder - Physician's order dated 7/6/22 listed Methadone 5 mg - Individual dosing log dated 7/12/22 noted 50 mg of Methadone administered. 3. Review on 7/12/22 of client #1204's record revealed: - Admitted: 3/30/21 - Diagnosis: Opioid Use Disorder - Physician's order dated 1/10/22 listed Methadone 160 mg - Individual dosing log dated 7/12/22 noted 160 mg of Methadone administered. 4. Review on 7/12/22 of client #1102's record revealed: - Admitted: 4/20/21 - Diagnosis: Opioid Use Disorder - Physician's order dated 6/2/22 listed Methadone titration down to 60 mg - Individual dosing log dated 7/12/22 noted 6 0mg of Methadone administered. 5. Review on 7/12/22 of client #1167's record revealed:	V 118		

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V 118	Continued From page 4 - Admitted: 12/4/20 - Diagnosis: Opioid Use Disorder - Physician's order dated 1/1/22 listed Methadone titration down to 55 mg - Individual dosing log dated 7/12/22 noted 55 mg of Methadone administered. 6. Review on 7/12/22 of client #1379's record revealed: - Admitted: 6/28/22 - Diagnosis: Substance Use history - Physician's order dated 7/12/22 listed Methadone 60mg - Individual dosing log dated 7/12/22 noted 60mg of Methadone administered. 7. Review on 7/12/22 of client #1044's record revealed: - Admitted: 8/29/19 - Diagnosis: Substance Use history - Physician's order dated 6/3/22 listed Methadone 45 mg can decrease by 10mg weekly up to 25 mg. - Individual dosing log dated 7/12/22 noted 20mg of Methadone administered. 8. Review on 7/12/22 of client #1110's record revealed: - Admitted: 6/10/20 - Diagnosis: Substance Use history - Physician's order dated 11/5/20 listed Methadone 160 mg - Individual dosing log dated 7/12/22 noted 160 mg of Methadone administered. 9. Review on 7/12/22 of client #1274's record revealed: - Admitted: 8/10/21 - Diagnosis: Substance Use history - Physician's order dated 8/10/21 listed	V 118		

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V 118	Continued From page 5 Methadone 220mg - Individual dosing log dated 8/10/21 noted 220mg of Methadone administered. 10. Review on 7/12/22 of client #1105's record revealed: - Admitted: 5/10/20 - Diagnosis: Substance Use history - Physician's order dated 1/4/22 "decrease 5mg/wk (milligram/week) up to 160/day..f/u (follow up) in 1 month" - Individual dosing log dated 7/12/22 noted 135 mg administered. Review on 7/13/22 of the facility's July 12, 2022 calibrations report revealed data to support: - twice at 5:11 AM & 5:12 AM - once at 5:13 AM, 5:14 AM, 6:00 AM, 6:27 AM, 7:07 AM, 9:10 AM, 10:01 AM, 11:02 AM and 11:03 AM Observation on 7/12/22 between 5:45AM-7:30 AM revealed the following: - LPN placed an empty medication cup on the electric scale (e-scale) to obtain a weight. - A pre-set test dosage of Methadone 100mg was dispensed from the MDMP into the empty medication cup. - LPN used a reference card as a guide. - The e-scale read variations of 12.8 gr (grams) and 12.6 gr - LPN manually turned the dial on the pump up or down depending on the reading and repeated the calibration Review on 7/12/22 of the reference card noted the following: - "Calibrate devices to 10 g water. - Dispense 5 additional tests without moving calibration dial.	V 118		

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V 118	Continued From page 6 - Average of last 5 calibrations +`1%. - 11.8 gr/100 mg average Methadone calibration range - 11.7-11.9 gr (117-119 ml) (milliliter) Calibration is Good" Interview on 7/12/22 the LPN stated: - Facility was closed on Sundays and holidays. - She calibrated the MDMP upon arrival to work around 5:00 AM - Calibrations were conducted hourly. - When the e-scale was above 11.9 gr or below 11.7 gr, manual adjustments were made to the MDMP - On 7/11/22, the RN Supervisor changed the tubing. The change in tubing caused inaccurate calibrations of the Methadone being dispensed. - Only one client had been administered medications around 6:00 AM. Later, she clarified "maybe up to four clients" had been administered medications. Interview on 7/12/22 the RN Supervisor stated: - She had not changed the tubing on the MDMP on 7/11/22. - Calibrations of the MDMP should be completed at least daily and when changes were made to the tubing. Observation on 7/12/22 between 10:00-10:30 AM revealed the following: - LPN recalibrated the pump using the same steps as the 5:45- AM-7:30 AM observations - The e-scale read variations of 12.8 gr, 12.1 gr, 11.5 gr Interview on 7/12/22 the LPN stated: - She attributed the change in calibrations due to the machine shaking when the Methadone was dispensed.	V 118		

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V 118	Continued From page 7 Review on 7/13/22 of the "Total dispensed by day" report dated 7/12/22 revealed: - 56 clients were administered and/or dispensed their individual Methadone dosages between 5:30 AM and 11:00 AM. Interview on 7/13/22 the RN Supervisor stated: - Inaccurate calibrations could result in clients receiving too little or too much Methadone. - The incorrect dosage could cause clients to experience withdrawals or increase cravings resulting in relapse. - Adverse effect on the respiratory and central nervous system could result if client received incorrect dosages. Interview on 7/13/22 the technician at the manufactory's warranty support line for the MDMP stated: - There are two forms of calibrations. - The first type of calibration was completed daily by the facility. - The second type of calibration involved the pump being serviced every 12-18 months. - Based on the inconsistency in maintaining the MDMP within range within a short time frame, a maintenance service would be recommended. - Anytime the reading was above 11.9 gr or below 11.7 gr, it would be out of range. Interview on 7/14/22 the Program Manager and RN Supervisor stated: - Prior to this interview, neither were aware the machine did not maintain calibrations - They were not aware the MDMP had to be sent off for service II. Example medication not administered as prescribed by physician.	V 118		

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V 118	Continued From page 8 Review on 7/12/22 of client #1105's record revealed: - Met eligibility for take home of Methadone was phase 6 that included 13 bottles for daily self administration - No physician's orders or notes that indicated she was seen by a physician after 1/4/22 - Medication dosing history Log between April-July 2022 reflected Methadone dosages below 160 mg were dispensed every 2 weeks to include but not limited to the following: 4/19/22-5/2/22 dispensed 155 mg 5/3/22-5/16/22 dispensed 150 mg 5/17/22-5/30/22 dispensed 145 mg 6/1/22-6/13/22 dispensed 145 mg 6/14/22 -6/27/22 dispensed 145 mg 6/30/22-7/11/22 dispensed 140 mg 7/12/22-7/25/22 dispensed 135 mg Observation on 7/12/22 between 6:05 AM and 6:20 AM revealed the following: - Client #1105 requested a decrease in her medication by 5 mg - At the time of this interview, client #1105 requested a decrease of 5 mg in her daily dose to the LPN. - Client #1105 was administered 135 mg to take onsite. - The Licensed Practical Nurse prepared and dispensed 13 take home bottles of Methadone 135 mg for client #1105. Interview on 7/12/22 client #1105 stated: - She requested the decrease in Methadone dosages during her appointment with the Facility's Physician in January 2022. - The Facility's Physician indicated "he was concerned" about her 5 mg bi-weekly dosage change.	V 118		

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V 118	Continued From page 9 - The Facility's Physician indicated she needed to follow up in a month. - She had not seen the Facility's Physician since January 2022. - If she wanted a decrease in dosage, the nurse at the window would honor her request. Interview on 7/12/22 the facility's Medical Director stated: - Tuesdays and Fridays were his days at the clinic. - He had not seen client #1105 since January per his notes. - The facility had switched computer programs for documentation of client information in January 2022. - Each Friday, client cases were discussed in a team meeting. - He was involved in the team meeting. - The counselor or someone should have discussed client #1105 during the weekly team meeting. Interview on 7/12/22 the RN Supervisor stated: - It was the facility's process to follow the physician's orders. - She had not been informed by the Medical Director of the need for the follow up appointment for client #1105. Review on 7/14/22 the facility's Plan of Protection dated 7/14/22 and submitted by the Program Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Nursing Supervisor will immediately monitor daily calibrations completed by dosing nurses. Pump will be cleaned on 7/14/2022 per policy. Tubing	V 118		

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V 118	Continued From page 10 will be changed on 7/14/2022. -Program Director and/or Nurse Supervisor will utilize treatment team documentation to follow up on progress of each patient presented each treatment team meeting. -Coaching/training will be provided to dosing nurse on policy related to calibrating and maintaining pump. Describe your plans to make sure the above happens. -Dosing nurse is required to turn in daily calibration log to Nursing Supervisor prior to leaving each shift. Pump maintenance log will be completed and monitored regularly. -Program Director and/or Nurse Supervisor will hold each other accountable for bringing the appropriate documentation to each treatment team for follow up. -Coaching/training will be provided verbally by reviewing 'Beginning the day-opening the pharmacy' from the New Nurse Onboarding Workbook and Resource Guide and followed up via email to explain the impact of not calibrating per policy." All clients served at the facility had a history of substance use and a diagnosis of Opioid Use Disorder. Each client was prescribed methadone as treatment for their chemical dependency. Review of client #1105's record revealed no physician's orders or notes that indicated she was seen by a physician after 1/4/22 and dosing logs which did not reflect the current physician orders. Client #1105 received lower dosages of	V 118		

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V 118	Continued From page 11 methadone than the prescribed amount. The facility could not provide Physicians' orders for client #1105 to reconcile the discrepancy or reflect the current administered dosage. The facility's methadone pump was not calibrated daily per policy, and during observation, was not calibrated within calibration parameters. The facility had not taken measures to have the pump calibrated professionally per policy, and staff were calibrating the machine manually. The potential for administering the incorrect dosage of methadone to all of the clients dosed at the facility, while the pump was out of calibration, constitutes serious neglect. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3, 000 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 118		
V 233	27G .3601 Outpt. Opiod Tx. - Scope 10A NCAC 27G .3601 SCOPE (a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. (b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual. (c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing	V 233		

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V 233	Continued From page 12 doses for a period not to exceed 180 days. (d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to offer two of ten audited clients (#1110 and #1274) an opportunity to effect constructive changes in lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. The findings are: Review on 7/13/22 of the facility's Positive Drug Screen Results policy revealed the following for clients without valid prescription or admits to illicit drug use such as cocaine which include but not limited to the following: - Documentation in the form of case notes - Encourage client to voluntarily increase their daily dose to eliminate cravings. - "Should a patient not desire to increase his/her current dose, clinical staff members will present these cases to the Medical Director for	V 233		

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V 233	Continued From page 13	V 233		

review, recommendations and evaluation of the adequacy of the medication dose...The Medical Director (facility's physician) is expected to exercise reasonable clinical judgment as a way to ensure that the organization complies with state and federal rules pertaining to the interpretation and use of positive drug screen results. Toward that end, the clinical staff (nurses and counselors/case managers) will ensure that the Medical Director is provided all pertinent information about the patient so that the most appropriate clinical decision can be made."

A. Review on 7/12/22 of client #1110's record revealed:
- Admitted: 6/3/20
- Diagnosis: Substance Use
- Physician's order dated 11/5/20 Methadone 160 milligrams (mg). No other changes to dosage amount noted.
- Urinary Drug Screens (UDS) yielded positive results for the following illicit substances between 1/01/21-7/7/22:

2021- out of 15 collections:
11 detected Amphetamines (AMPH)
3 detected Cocaine (Coc)
15 detected Tetrahydrocannabinol (THC)
15 detected Fentanyl (FENT)

2022:
No collections for March and May
Out of 4 collections:
3 detected AMPH, THC and FENT.
1 detected AMPH, THC, FENT and OPS (opiates)

- Case notes indicated the following:

5/6/22 individual counseling..upset over observed uds...not working in area where he could be a guest dose. Reported no withdrawals
6/3/22 treatment plan established
6/17/22 inpatient referral to another inpatient

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	MHL092-962	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO TREATMENT OF NC, LP DBA NEW SE/	3911 NEW BERN AVENUE, UNIT A RALEIGH, NC 27610

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V 233	Continued From page 14 care...put on behavior contract Review on 7/13/22 and 7/14/22 of the facility's weekly "Treatment Meeting Notes" between 1/1/22-7/12/22 revealed the following for client #1110: - 12/31/21: scheduled appointment with Medical Director - 3/24/22: referral made for stability - 3/31/22: discharge - 4/7/22: "SIT" with physician - 6/17/22: drug screen next week, behavior contract Interview on 7/12/22 client #1110 stated: - He did not attend group. - His significant other engaged in Substance Use. For this reason, he had no take homes. - He "slipped from time to time. Each time I mess up, they drug test me." - He saw his counselor monthly. Counselor #2 had spoken with him about illicit drug use and relapse. Interview on 7/13/22 Counselor #2 stated: - Client #1110 was discussed with the former Medical Director "a lot." - Did not know if they (the staff) had discussed client #1110 with the current Medical Director - The current Medical Director had treated client #1110 since January of 2022 - It was recommended that client #1110 go to an inpatient facility for detoxification, however client #1110 refused to go because he had to work. - The previous Medical Director would increase the dosage for client #1110 because he continued to use. - Client #1110 needed an electrocardiogram (EKG).	V 233		

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V 233	Continued From page 15 - Client #1110 "wouldn't find the time to get the EKG." - Dose is going down now because he needed a physical. - He hasn't done the annual physical with the current Medical Director and therefore the methadone dose will continue to go down until he completed the physical. - He had a behavior contract with the former Medical Director. He was noncompliant with the contract. - He was scheduled for staffing by the treatment team on 7/15/22 - With regards to the positive drug screens, this clinic did not like to do an administrative discharge and detox clients out. - The facility has had a low census in the past, and they have kept the clients instead of discharging them, "to keep the numbers up." Interview on 7/12/22 the Medical Director stated: - He was hired in October 2021. - He had not seen client #1110 - Had he known of the case, he would have recommended therapy or increase in medication. - The counselor should have discussed client #1110's non compliance behaviors for review during the weekly team meetings held on Friday. Interview on 7/13/22 the Registered Nurse (RN) Supervisor stated: - Client #1110 had a history of missing scheduled appointments. - The facility had capability of "flagging client's record" before the medication was administered. - Client #1110 was supposed to see the Medical Director on 7/12/22 as it was prescheduled. - The morning of 7/12/22, client #1110 was in a hurry to leave after his morning dose was	V 233		

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V 233	Continued From page 16	V 233		

administered.
- Client #1110 responded about the missed 7/12/22 appointment, "it slipped" his mind.

B. Review on 7/12/22 of client #1274's record revealed:
- Admitted: 8/10/21
- Diagnosis: Substance Use
- Client transferred from another opioid treatment clinic to this facility
- Physician's order dated 8/20/21 noted Methadone 220mg
- UDS yielded positive results for the following illicit drugs
  2021: out of 4 collections between August-December
    4 detected Coc
  2022: out of 6 collections between January-June:
    2 detected Coc
    1 detected Coc and FENT
    3 detected Coc and Ethanol (ETOH)
- Nursing notes between 4/1/22-7/12/22 reflect:
  4/4/22-5/16/22- Administrative detoxification due to failure to comply with state required labworks.
  5/2022- 7 absences from dosing
  6/2022-12 absences from dosing
  7/2022- 7 absences from dosing
  7/9/22 and 7/10/22- unable to administer methadone due to breathalyzer reading of .073.
- Counselor notes between 04/2022-07/2022
  No increase in the number of sessions
  5/18/22 note of treatment review. Placed on behavior contract and committed to attend treatment 4 days a week or would meet with medical director for further review.
  6/2022- 8 separate attempts to contact due to missed dosages. Counselor noted "phone not in service."

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V 233	Continued From page 17 - 5/18/22 Care Coordinator note written by RN Supervisor referenced client weight loss of 10 pounds due to Coc use. - No physician's note to address weight loss. Review on 7/13/22 and 7/14/22 of the facility's weekly "Treatment Meeting" Notes between 12/1/21-7/12/22 revealed the following for client #1274: - 12/31/21: Scheduled appointment with Medical Director - 7/1/22: Breathalyzer implemented and dose reviewed Interview on 7/13/22, Counselor #3 stated: - Started working at the agency in 2022. - She was aware of the concern with client #1274's lack of attendance for Methadone treatment, monthly uds positive for Coc, non compliance with contracts, delay in obtaining required labworks and refusal to attend mental health counseling. - She felt the facility was "trying" to meet the needs of client #1274 based on the client's non compliance with all requirements of treatment. - Client #1274's case was only reviewed in July 2022. Interview on 7/12/22 the Medical Director stated: - Per his notes and the computer, he had not seen client #1274. - He was unaware of her case. - Had concern over her dosage being high as well as the combination of Coc, Methadone and ETOH. - He worked at the facility two days a week. - The facility was in the process of hiring a Family Nurse Practioner to assist with the caseload and provide services the days he did not work.	V 233		

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V 233	Continued From page 18 Interview on 7/14/22 the Program Director stated: - She transferred from another agency in late 2021 - Prior to this survey she was aware of concerns regarding both clients #1110 and #1274. - She felt the team had addressed the issues during the meeting but awaited con-census from all team members regarding treatment. Review on 7/14/22 the facility's Plan of Protection dated 7/14/22 and submitted by the Program Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Program Director and/or Nurse Supervisor will utilize treatment team documentation (log) from previous meeting to follow up on progress of each patient presented each treatment team meeting. -Complete an audit of patients who continuously use illicit substances. Present those patients to treatment team for a plan of action. Describe your plans to make sure the above happens -Program Director and/or Nurse Supervisor will hold each other accountable for bringing the appropriate documentation/binder to each treatment team for follow up. -Program Director and/or Nurse Supervisor will present patients to Medical Director/Nurse Practitioner for their plan of action for each patient with continued illicit use." All clients served at the facility had a history of	V 233		

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V 233	Continued From page 19 substance abuse and diagnosis of Opioid Use Disorder. Each client was prescribed methadone as a treatment for their chemical dependency. Client #1274 had engaged in treatment at the facility in August of 2021. She continued to provide urine drug screens positive for cocaine, alcohol, and marijuana on a monthly basis. Client #1110 engaged in treatment at the facility June of 2020. He continued to provide drug screens monthly that were positive for cocaine, amphetamines, and Fentanyl. Client #1274 was prescribed a dosage of 220 mg of methadone while she continued to actively use illicit drugs. Client #1110 was prescribed 160 mg of methadone for over a year while he actively used illicit drugs. Both clients were resistant to treatment interventions which included recommendations to inpatient detoxification, increased counseling sessions, and were noncompliant with their behavioral contracts as well as providing required lab work, physical exams and electrocardiography (EKG) tests. Neither client #1274, nor client #1110 demonstrated constructive changes in his/her lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. The facility failed to address clients #1274 and #1110 continued illicit drug use while using the prescribed methadone treatment which is detrimental to the health, safety and welfare of the clients. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 233		