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 |
|---|---|---|---|
| | MHL011-335 | A. BUILDING: ______<br>B. WING ______ | R<br>08/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MOUNTAIN HEALTH SOLUTIONS - ASHEVILLE** | **2 MCDOWELL STREET<br>ASHEVILLE, NC 28801** |

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| V 000 | INITIAL COMMENTS<br><br>An annual, follow up and complaint survey was completed on August 8, 2022. The complaint was substantiated (Intake #: NC00183453). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.<br><br>The census at the time of the survey was 206. The survey sample consisted of audits of 10 current clients. | V 000 | | |
| V 112 | 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(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.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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 obtained. | V 112 | | |

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| V 112 | Continued From page 1 | V 112 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that treatment plans were reviewed at least annually for 3 of 10 audited clients (Client's #3, #8 and #9). The findings are:

Review on 8/4/22 of Client #3's record revealed:
-Admission date: 1/28/20
-Diagnoses: Opioid Use Disorder, severe, Generalized Anxiety Disorder, Major Depressive Disorder, recurrent, and Borderline Personality Disorder.
-The most recent treatment plan was dated 5/14/21.

Review on 8/4/22 of Client #8's record revealed:
-Admission date: 7/14/20
-Diagnosis: Opioid Use Disorder, Severe.
-The most recent treatment plan was dated 5/5/21.
-The client signed the treatment plan on 5/5/21; the counselor signed, but did not date the plan.

Review on 8/4/22 of Client #9's record revealed:
- Admission date: Re-Admission on 7/7/21.
- Diagnosis: Opioid Use Disorder, Severe.
-The most recent treatment plan was dated 6/8/21.

Interview on 8/4/22 with the Clinical Manager revealed:

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| V 112 | Continued From page 2<br>-They had been in the process of updating and scanning files to their electronic system.<br>-After researching, he could not find updated treatment plans for the above clients.<br><br>Interview on 8/4/22 with the Clinic Director revealed:<br>-He acknowledged that treatment plans need to be updated. | V 112 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to implement their emergency plan to notify the licensing agency, Division of Health Service Regulation/Mental Health Licensure (DHSR/MHL) of an emergency. The findings are:<br><br>Review on 8/5/22 of the facility "Emergency | V 114 | | |

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| V 114 | Continued From page 3 | V 114 | | |

Action Plan" last reviewed September 2019 revealed:
-"...8. After the emergency/disaster situation has abated:...f. Per your state specific requirements, the state licensing agency should be contacted if the emergency will result in any disruption of service or adversely impact the community served...."

Review on 8/4/22 of facility incident reports from May 2022 through 8/3/22 revealed:
-7/11/22 - 6:00 p.m. - "Level I - Major - Rear building fire with limited damage."
-"CD [Clinic Director] was informed...at approximately 10pm on Monday evening 7/11/22 that the fire alarm was triggered...Asheville FD [Fire Department] had been dispatched...
-a fire had broken out in the rear of the building...damage to the primary electrical conduit and meter box was evident...
-a strong odor of smoke filled the building...
-CD engaged in efforts to notify SOTA [State Opioid Treatment Authorities], the alternate dosing site [name of facility], staff and patients. For the next 3 days, 7/12-7/14, patients received care at [alternate dosing facility]...
-A mobile dosing unit arrived on 7/14 and at time of this writing the unit is still being set up and configured. The plan is to initiate mobile dosing on-site effective 7/15 until permission is received to re-occupy the building."

Review on 8/4/22 of facility records revealed:
-no documentation the facility made any attempts to notify the licensing agency, DHSR/MHL, of the fire emergency and impact on client care and services.

Observation and interview on 7/19/22 at 7:30 a.m. revealed:

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| V 114 | Continued From page 4<br>-In the staff and client parking lot was a white van, a table set up outside the van and multiple chairs set up under a pop-top tent.<br>-The Clinic Director and Clinical Manager met surveyors in the parking lot at that time.<br>-They informed surveyors of the fire (above incident) and stated clients dosed at an alternate facility Tuesday-Thursday (7/12/22-7/14/22).<br>-A staff member flew to New Hampshire to retrieve the mobile dosing van (observed upon surveyor's arrival).<br>-No clients "...missed doses or had clinical emergencies..." as a result of this incident.<br>-SOTA and the DEA [Drug Enforcement Administration] came by this morning and both approved temporary use of the mobile unit.<br>-They hoped electricity could be restored tomorrow (7/20/22) and be able to occupy the building by (7/22/22).<br>-The Clinic Director "didn't even think about it [notifying DHSR/MHL]...with so much going on...."<br><br>Observation and interview on 7/22/22 at 11:30 a.m. with the Clinic Director revealed:<br>-They re-opened the facility to normal operation on 7/21/22.<br>-The smoke was cleared from the building.<br>-The mobile van was no longer in the parking lot. | V 114 | | |
| V 131 | G.S. 131E-256 (D2) HCPR - Prior Employment Verification<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. | V 131 | | |

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| V 131 | Continued From page 5 | V 131 | | |
| | This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hiring 1 of 3 audited staff (Counselor #1). The findings are:<br><br>Review on 8/4/22 of Counselor #1's personnel record revealed:<br>-Date of hire was 2/28/22<br>-HCPR accessed on 3/3/22.<br><br>Interview on 5/4/22 with the Clinic Director (CD) revealed:<br>-Counselor #1 was offered the position in mid to late February 2022 with a projected start date of 3/7/22.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | | | |
| V 136 | 27G .0402 (C-F) License Issuance<br><br>10A NCAC 27G .0402 LICENSE ISSUANCE<br>(c) DFS shall conduct an on-site inspection to determine compliance with all rules and statutes. If the facility is operated by or contracted with an area program, DFS may, in lieu of conducting an on-site inspection, accept written verification from the area program or DMH/DD/SAS that the area program or DMH/DD/SAS has conducted an on-site review and the facility is in compliance with rules and statutes. The written verification | V 136 | | |

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| V 136 | Continued From page 6<br>shall be in such form as DFS may require.<br>(d) DFS shall issue a license after it determines a facility is in compliance with:<br>(1) Certificate of Need law (G.S. 131E-183) and Certificate of Need rules as codified in 10 NCAC 3R .2400, .2500, or .2600, whichever is applicable;<br>(2) Building Code and physical plant requirements in these Rules;<br>(3) Annual fire and safety and sanitation requirements, with the exception of a day/night or periodic service that does not handle food for which a sanitation inspection report is not required; and<br>(4) Applicable rules and statutes.<br>(e) Licenses shall be issued to the specific premise for types of services indicated on the application.<br>(f) A separate license shall be required for each facility which is maintained on a separate site, even though the sites may be under the same ownership or management.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide services at the specific premises for which they were licensed. The findings are:<br><br>Observation and interview on 7/19/22 at 7:30 a.m. revealed:<br>-In the staff and client parking lot was a white van, a table set up outside the van and multiple chairs set up under a pop-top tent.<br>-The Clinic Director and Clinical Manager met surveyors in the parking lot at that time. | V 136 | | |

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| V 136 | Continued From page 7<br>-They informed surveyors of an incident on 7/11/22 (fire) and stated clients dosed at an alternate facility Tuesday-Thursday (7/12/22-7/14/22).<br>-A staff member flew out of state to retrieve the mobile dosing van (observed upon surveyor's arrival).<br>-No clients "...missed doses or had clinical emergencies..." as a result of this incident.<br>-SOTA [State Opioid Treatment Authorities] and the DEA [Drug Enforcement Administration] came by this morning and both approved temporary use of the mobile unit.<br>-They hoped electricity could be restored tomorrow (7/20/22) and be able to occupy the building by (7/22/22).<br>-They were not aware they needed to notify the Division of Health Service Regulation/Mental Health Licensure.<br><br>Observation and interview on 7/22/22 at 11:30 a.m. with the Clinic Director revealed:<br>-They re-opened the facility to normal operation on 7/21/22.<br>-The smoke was cleared from the building.<br>-The mobile unit was no longer in the parking lot.<br><br>Interview on 8/4/22 with the Clinic Director and Clinical Manager revealed:<br>-The clients received their doses of medication via the mobile unit which was parked in the staff and client parking lot (during operating hours) from 7/15/22 through 7/20/22. | V 136 | | |