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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 7/29/22. The complaints were substantiated (Intake #s NC00190130 and NC00190153). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization for Individuals Who are Acutely Mentally Ill, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program, and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program. The facility had a census of 11. The survey sample consisted of audits of 4 current clients.	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:	V 105		

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V 105	Continued From page 1 (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility 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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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement written policies that include the adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. The findings are:

Cross Reference: 10A NCAC 27G.0205 (V112)
Based on record review and interview, the facility failed to develop treatment plans within 30 days of admission for 2 of 4 audited clients (Clients #1 and #4) and failed to develop strategies for 2 of 4 audited clients (Clients #2 and #3).

Cross Reference: 10A NCAC 27G.0209 (V118)
Based on observation, interview and record review, the facility failed to develop MARs of all drugs that were self-administered affecting 3 of 3 audited clients who self-administered their medications (Clients #1, #2 and #3).

Cross Reference: 10A NCAC 27G.1101 (V171)
Based on record review and interview, the facility failed to provide an individual and group Partial Hospitalization Program (PHP) for acutely mentally ill individuals within the scope of the license affecting 4 of 4 audited clients (Clients #1, #2, #3 and #4).

Cross Reference: 10A NCAC 27G.1102 (V172)
Based on record review and interview, the facility failed to have a minimum ratio of one staff

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member present for every six clients at all times.

Cross Reference: 10A NCAC 27G.4401 (V266)
Based on record review and interview, the facility failed to provide a structured individual and group Substance Abuse Intensive Outpatient Program (SAIOP) to assist adults whose primary diagnosis was substance-related within the scope of the license.

Cross Reference: 10A NCAC 27G.4402 (V267)
Based on record review and interview the facility failed to ensure each direct care staff received continuing education that included understanding the nature of addiction, the withdrawal syndrome, group therapy, family therapy and relapse prevention for 3 of 3 audited staff (Group Facilitator, Primary Therapist and Clinical Director).

Cross Reference: 10A NCAC 27E.0107 (V536)
Based on interview and record review, the facility failed to ensure staff completed an initial training in the use of alternatives to restrictive interventions for 2 of 3 staff (Clinical Director and Primary Therapist) and failed to ensure 1 of 3 staff (Group Facilitator) completed an annual refresher course.

Review on 7/27/22 of the Plan of Protection dated 7/27/22 written by the Chief Executive Officer revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?

10A NCAC 27G.0201/V105/Type A1: Cross references - Standard of Practice
How- Quality Assurance team will ensure Policies for Willow Place program are complete and being followed

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When- Weekly QA meetings - Tuesday and Thursday
Who- Medical Director, Executive Director, Clinical Director, Program Director and Assistant to Medical Director
Who Monitors- Executive Director

10A NCAC 27G.0205/V112; Treatment Plans
How- Treatment plans will be completed within 5 business days
When- Immediate policy update
Who- Clinical Director will disseminate information to clinical team
Who Monitors- Clinical Director will chart audit weekly and provide written corrective action plans for staff not following policy

10A NCAC 27G.0209(c)/V118; Medications
How- MAR will be completed for each client
When- Immediately for all current clients, upon intake for new clients
Who- Clinical Director will disseminate information to clinical team
Who Monitors- Clinical Director will chart audit weekly

10A NCAC 27G.1101/V171; PHP Scope
How- Willow Place will operate within framework of PHP scope/MH counseling
When- Immediate adjustment of scheduling
Who- Clinical Director
Who Monitors- Clinical Director will ensure appropriate staff is facilitating PHP programming

10A NCAC 27G.1102/V172; PHP Staff
How- PHP therapist will have no more than 6 clients
When- ASAP additional therapist will be hired
Who- Program Director will hire
Who Monitors- Clinical Director will monitor

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V 105	Continued From page 5 caseloads 10A NCAC 27G.4401/V266; IOP Scope How- Willow Place will operate within framework of IOP scope/SUD counseling When- Immediate adjustment of scheduling Who- Clinical Director Who Monitors- Clinical Director will ensure appropriate staff is facilitating PHP programming 10A NCAC 27G.4402/V267 and IOP Staff How- IOP therapist will have no more than 12 clients When- ASAP additional therapist will be hired Who- Program Director will hire Who Monitors- Clinical Director will monitor caseloads 10A NCAC 27E.0107/V536. NCI Training How- NCI training will be completed within 30 days of hire and immediately for all current staff When- Immediately schedule [Name of Trainer] for NCI training Who- Program Director will disseminate information to staff Who Monitors- Program Director will ensure all staff has required training in Monthly QA meeting Describe your plans to make sure the above happens." Review on 7/29/22 of an addendum to the Plan of Protection dated 7/29/22 written by the Chief Executive Officer revealed the following was added: -"10A NCAC 27G.0205/V112; Treatment Plans How- Treatment plans will be completed within 5 business days, current plans will be complete by end of business Monday August 1, 2022 by primary therapist for each client	V 105		

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When- Immediate policy update to reflect that treatment plans are completed within 5 business days and each client will be reviewed in treatment team meeting weekly to ensure compliance

10A NCAC 27G.0209(c)/V118; Medications
How- MAR will be completed for each client by Medical assistant by end of business August 1, 2022, moving forward Housing Team Lead will audit these weekly for accuracy. Medical assistant will update every Wednesday post medical appts [appointments] with psyc [psychiatrist].

10A NCAC 27G.1101/V171; PHP Scope
How- Willow Place will operate within framework of PHP scope/MH counseling- New therapist begins August 15, 2022, she will assist in being able to keep programs from overlapping. In the meantime we are adjusting the programming based on our current census. We have a new group facilitator who started as well and can offer some additional separation. Executive Director and Clinical Director working together to have a new schedule in place by August 1, 2022.

10A NCAC 27G.4401/V266; IOP Scope
How- Willow Place will operate within framework of IOP scope/SUD counseling- New therapist begins August 15, 2022, she will assist in being able to keep programs from overlapping. In the meantime we are adjusting the programming based on our current census. We have a new group facilitator who started as well and can offer some additional separation. Executive Director and Clinical Director working together to have a new schedule in place by August 1, 2022.

10A NCAC 27E.0107/V536. NCI Training
How- NCI training will be completed within 30

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days of hire and immediately for all current staff, by August 19, 2022."

Willow Place is a multi-licensed out patient program for women who suffer from acute mental-illnesses and/or substance use disorders. Diagnoses of clients who attended the program included: Post-Traumatic Stress Disorder, Borderline Personality Disorder, Bipolar I Disorder, Bipolar II Disorder, Attention-Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Generalized Anxiety Disorder, Unspecified Feeding/Eating Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Major Depressive Disorder, Alcohol Use Disorder, Opiate Use Disorder, Stimulant Use Disorder, and Sedative Use Disorder. The facility operated multiple programs as one program and did not individualize according to the clients' needs for treatment. Clients reported the groups were disorganized and not helpful for their needs. One client who had mental illness diagnoses only, had to attend groups involving substance abuse, which she had no history of this. The facility had one primary therapist who saw clients from both the PHP and SAIOP programs. The primary therapist had a caseload of 9 clients during the survey; she carried a caseload of 9 to 11 clients consistently and was not able to see the clients as often as they needed. Client #1 went 13 days after admission before she had a therapy session, Client #2 went 9 days after admission and 8 days since her last session on 7/12/22; Client #3 saw the therapist 3 days after admission, and Client #4 went 5 days after admission, she had 2 weeks between sessions from 5/24/22 to 6/17/22, and one week from 6/21/22 to 7/5/22. She had a relapse 3 weeks into the program. Clients were asked to do a

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V 105	Continued From page 8 biofeedback session in place of a therapy session. Some clients did not prefer the biofeedback bed and wanted to talk to their therapist instead. This opportunity was not given to them. The Clinical Director offered doing a relaxation tape or coloring if clients didn't like the biofeedback therapy. Client #1 had been at the facility for approximately a month and a half and had no treatment plan. Client #4 was admitted in April and discharged in July without a treatment plan being developed. One client felt like all the progress she made was on her own. The facility had no MARs for three clients who self-administered their medications. It was undetermined if clients were taking their medications as ordered. The Group Facilitator, Primary Therapist and Clinical Director did not have documented continuing education required for licensure and relevant to the needs of the clients they serve. Two staff members did not have restrictive intervention training since being employed at the facility and one staff member's training had expired. 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 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN	V 112		

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V 112	Continued From page 9 (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop treatment plans within 30 days of admission for 2 of 4 audited clients (Clients #1 and #4) and failed to develop strategies for 2 of 4 audited clients (Clients #2 and #3). The findings are: Review on 7/20/22 of Client #1's record revealed: -Admitted 5/30/22. Diagnosis of Alcohol Use Disorder, moderate.	V 112		

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Review on 7/20/22 of Client #1's BioPsychoSocial assessment dated 5/30/22 revealed:
-A history of verbal and physical abuse and substance abuse.
-"Chief complaint in own words - relapse on alcohol, I need to become financially stable on my own and not be dependent on my parents."
-The assessment was not signed.
-No documentation of a treatment plan.

Interview on 7/21/22 with Client #1 revealed:
-Her goals were "How to maintain sobriety, gaining independence, learning how to cope with triggers...building up network again."
-She did not remember discussing this with her therapist.
-It was "almost 3 weeks (after admission) before I met with someone (therapist)."

Review on 7/20/22 of Client #2's record revealed:
-Admitted 4/13/22.
-Diagnoses of Autism Spectrum Disorder, Generalized Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Avoidant/Restrictive Food Intake Disorder, Bipolar I Disorder, Borderline Personality Disorder, Unspecified Feeding/Eating Disorder, Panic Disorder, unspecified, and Obsessive-Compulsive and Related Disorder.

Review on 7/20/22 of Client #2's BioPsychoSocial assessment dated 4/13/22 revealed:
-Her goals were to gain independence and self-regulation skills.
-She had a history of physical and sexual abuse and "no healthy way to process" what happened to her.
-"PHP (Partial Hospitalization Program) to build her arsenal of self-regulation tools and begin

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working on her eating disorder behavior that has not been treated."

Review on 7/20/22 of Client #2's most recent treatment plan dated 5/18/22 revealed:
-Goals of PTSD.
-Terminate the destructive behavior that serves to maintain escape and denial.
-Develop healthy and rewarding interpersonal relationships.
-Terminate dichotomous thinking.
-Unmanaged anger and/or fear of abandonment.
-Develop and demonstrate coping skills to reduce mood swings and control impulses.
-Restore normal eating patterns, healthy weight maintenance and a realistic appraisal of body size.
-Enhance ability to effectively cope with the full variety of life's worries and anxieties.
-Stabilize anxiety level while increasing ability to function daily.
-Per the electronic record the treatment plan was "pending signature" by the Clinical Director.

Interview on 7/21/22 with Client #2 revealed:
-She came to the facility "strictly for mental health services."
-They have one therapist here who worked with all the clients.
-She hadn't talked to a therapist in over a week.
-She "had a break down this weekend because didn't have a Friday session to prepare me for this weekend...can't call anyone on the weekend..no 24-hour support...all they asked was do you need to call 911 or urgent care...called my mom."

Review on 7/20/22 of Client #3's record revealed:
-Admitted 5/29/22.
-Diagnoses of Unspecified Feeding/Eating

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Disorder, Bipolar II Disorder, PTSD, and Alcohol Use Disorder, moderate.

Review on 7/20/22 of Client #3's BioPsychoSocial assessment dated 5/30/22 revealed:
-Her mother and father had passed away.
-She had an extensive history of substance abuse.
-She recently gained/lost significant amount of weight.
-Her self-esteem was connected to her weight and she had a history of treatment for eating disorder.
-Her short-term goals were to create a sober support system, make new friends, attend meetings, get on her feet and become more stabilized.
-Her long-term goals were to finish 12-step program, have a serious relationship, go back to school, and move out of town.

Review on 7/20/22 of Client #3's most recent treatment plan dated 6/23/22 revealed:
-Goals of Eating disorder and obesity.
-Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder.
-Restore normal eating patterns, healthy weight maintenance, and a realistic appraisal of body size.
-Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals and self-harm behavior.

Review on 7/20/22 and 7/22/22 of Client #4's record revealed:
-Admitted 4/24/22.
-Discharged 7/22/22.
-Diagnoses of Major Depressive Disorder, GAD, PTSD, Opiate Use Disorder, Stimulant Use

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Disorder, Sedative Use Disorder, Insomnia, Attention-Deficit Hyperactivity Disorder, and Scoliosis.

Review on 7/20/22 of Client #4's BioPsychoSocial assessment dated 4/25/22 revealed:
-She had a history of childhood trauma, physical abuse, sexual, and emotional abuse.
-She was extremely insecure, didn't know how to make friends or build a sober community.
-Childhood trauma led to extensive substance use.
-Her goals for treatment were to stay sober, work on self-worth, make money and save, work on trauma, and ..."resolve unresolved problems I have."
-There were no signatures on the assessment.
-No documented treatment plan.

Interview on 7/21/22 with Client #4 revealed:
-She did not discuss her goals for treatment with a therapist.
-The Group Facilitator was her assigned therapist; "She's not a natural therapist, [Primary Therapist] is the only therapist."
-Her goals were to stay sober, process trauma and have a plan when she left the program, make sure she had support.
-She wanted to work on self-esteem, and how to not let others affect her mood; instead she was asked, "why are you letting other's moods affect you?"
-She had a relapse 3 weeks into the program.
-She felt like all her progress was due to what she had done on her own.

Review on 7/22/22 of the Primary Therapist's job duties (undated) revealed:
-Title: Primary Mental Health Counselor.
-"ESSENTIAL FUNCTIONS AND JOB DUTIES:

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V 112	Continued From page 14 ...Creates Crisis plan and initial treatment plan on the day of admission with client...Creates treatment plan for client within 5 days of admission or at each LOC [Level of Care] change incorporating all care for client including medical care, family sessions, and information gathered in all assessments. Creates a treatment plan review for each client every 30 days from treatment plan creation...." Interview on 7/25/22 with the Primary Therapist revealed: -She was responsible to complete the client's assessments, and treatment plans. -She currently had a case load of 12 clients and consistently had 9 - 11 clients since she was the only therapist. -"That's why documentation slipped. I am talking about treatment goals and we are actively working on things." -She usually did the client's assessment and treatment plans during their second session. -She thought all clients had at least one treatment plan. Interview on 7/25/22 with the Group Facilitator revealed: -Her primary job was group facilitator; she ran eight groups throughout the week. -She had 2 clients on her caseload, one of which was just discharged on Friday (7/22/22). -She was not responsible for any treatment plans; this was the agreement she made prior to taking a caseload. -She would help out as long as she wasn't responsible for any assessments/treatment plans. -She did not have any of the clients treatment plans on outings and had not seen any of their crisis plans. -If a client was in crisis during an outing she	V 112		

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V 112	Continued From page 15 would let the Primary Therapist know. Interview on 7/22/22 with the Clinical Director revealed: -The Primary Therapist was responsible to complete the assessments and treatment plans. -She was aware they were behind on treatment plans and "we've been addressing that." 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 112		
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;	V 118		

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(D) date and time the drug is administered; and
(E) name or initials of person administering the drug.
(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, interview and record review, the facility failed to develop MARs of all drugs that were self-administered affecting 3 of 3 audited clients who self-administered their medications (Clients #1, #2 and #3). The findings are:

Review on 7/20/22 of Client #1's record revealed:
-Admitted 5/30/22.
-Diagnosis of Alcohol Use Disorder, moderate.
-There were no MARs in the client's records.

Observations on 7/20/22 at 3:07 p.m. of Client #1's medications revealed:
-Prazosin 1 mg (milligrams) - 2 capsules at bedtime (HS).
-Prazosin 2 mg - 1 capsule at HS.
-Trazodone 150 mg - 2 tablets at HS.
-Venlafaxine HCL Extended Release (ER) 75 mg - 1 capsule in a.m.
-Lamotrigine 200 mg - 2 tablets in a.m.
-Quetiapine Fumarate (Seroquel) 200 mg - 1 tablet at HS.
-Quetiapine Fumarate 100 mg - 2 tablets at HS.
-Venlafaxine HCL ER 150 mg - 1 capsule in a.m.

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-Hydroxyzine PAM 50 mg - 1 capsule 2 times a day PRN (as needed) for Anxiety.

-Review on 7/21/22 of Client #1's physicians orders revealed:
-5/31/22 - Client able to self-administer her medications.
-6/30/22 - Quetiapine Fumarate 100 mg - 2 tablets at HS.
-7/5/22 - Prazosin 2 mg - 1 capsule at HS; Quetiapine Fumarate 200 mg - 1 tablet at HS.
-Discontinued 7/20/22 - Lamotrigine 200 mg - 2 tablets in a.m.
-7/21/22 - Prazosin 1 mg - 2 capsules at HS; Trazodone 150 mg - 2 tablets at HS; Venlafaxine HCL ER 75 mg - 1 capsule in a.m.; Venlafaxine HCL ER 150 mg - 1 capsule in a.m.

Interview on 7/21/22 with Client #1 revealed:
-She was responsible to take her own medications.
-She filled her medication planner weekly at the facility.

Review on 7/20/22 of Client #2's record revealed:
-Admitted 4/13/22.
-Diagnoses of Autism Spectrum Disorder, Generalized Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Avoidance/Restrictive Food Intake Disorder, Bipolar I Disorder, Borderline Personality Disorder, Unspecified Feeding/Eating Disorder, Panic Disorder, Unspecified, and Obsessive-Compulsive and Related Disorder.
-There were no MARs in the client's records.

Observations on 7/20/22 at 2:36 p.m. of Client #2's medications revealed:
-Lo Loestrin FE 1-10 - 1 tablet every day.
-Sucralfate 1 gm (gram) - 1 tablet 3 times a day.

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-Gabapentin 300 mg - 2 capsules at HS.
-Gabapentin 400 mg - 1 capsule 2 times a day.
-Topiramate 50 mg - 1 tablet every a.m.
-Topiramate 100 mg - 1 tablet 2 times a day.
-Prazosin 1 mg - 1 capsule at HS.
-Prazosin 5 mg - 1 capsule at HS.
-Hyoscyamine 0.125 mg sublingual (SL) - Dissolve 1 tablet under tongue 3 times a day.
-Buspirone HCL 15 mg - 1 tablet 4 times a day.
-Hydroxyzine PAM 50 mg - 2 capsules 4 times a day.
-Trazodone 150 mg - 1 capsule at HS.
-Escitalopram 20 mg - 1 tablet a day.
-Omeprazole Dr 20 mg - 1 capsule every day.
-Perphenzaine 2 mg - 1 tablet 2 times a day.
-Tegretol 200 mg - 1 tablet 3 times a day.
-Propranolol 10 mg - 1 tablet 3 times a day.
-Loperamide 2 mg - 1 capsule every a.m.
-L-Methyl Folate 15 mg - 1 every day.
-Cyclobenzaprine 10 mg - 1 tablet 2 times a day PRN muscle aches.
-Meclizine 25 mg - 1 tablet every 4 hours PRN.

Review on 7/21/22 of Client #2's physician orders revealed:
-4/14/22 - Client able to self-administer her medications.
-5/3/22 - Lo Loestrin FE 1-10 - 1 tablet every day; L-Methyl Folate 15 mg - 1 every day; Hyoscyamine 0.125 mg sublingual (SL) - Dissolve 1 tablet under tongue 3 times a day; Cyclobenzaprine 10 mg - 1 tablet 2 times a day PRN muscle aches; Meclizine 25 mg - 1 tablet every 4 hours PRN.
-5/4/22 - Loperamide 2 mg - 1 capsule every a.m.
-5/5/22 - Gabapentin 400 mg - 1 capsule 2 times a day.
-5/12/22 - Tegretol 200 mg - 1 tablet 3 times a day; Propranolol 10 mg - 1 tablet 3 times a day; Sucralfate 1 gm - 1 tablet 3 times a day;

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Gabapentin 300 mg - 2 capsules at HS; Topiramate 50 mg - 1 tablet every a.m.; Topiramate 100 mg - 1 tablet 2 times a day; Prazosin 1 mg - 1 capsule at HS; Prazosin 5 mg - 1 capsule at HS; Buspirone HCL 15 mg - 1 tablet 4 times a day; Hydroxyzine PAM 50 mg - 2 capsules 4 times a day; Trazodone 150 mg - 1 capsule at HS; Escitalopram 20 mg - 1 tablet a day.
-7/5/22 - Omeprazole Dr 20 mg - 1 capsule every day; Perphenzaine 2 mg - 1 tablet 2 times a day.

Interview on 7/21/22 with Client #2 revealed:
-She had a locked box for her medications.
-She filled up a week's worth of her medications at the facility.
-If she ran out of PRNs over the weekend she couldn't get it because they were kept locked at the facility.

Review on 7/20/22 of Client #3's record revealed:
-Admitted 5/29/22.
-Diagnoses of Unspecified Feeding/Eating Disorder, Bipolar II Disorder, PTSD, and Alcohol Use Disorder, moderate
-There were no MARs in the client's records.

Observation on 7/20/22 at 2:00 p.m. of Client #3 and the Program Director in the medication storage room revealed:
-The Program Director retrieved Client #3's medications from the locked drawer.
-Client #3 had plastic medication planners and filled a week's worth of medications independently.
-The Program Director observed as the client took the pills from each prescription bottle and filled each day.

Observations on 7/20/22 at 2:06 p.m. of Client

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V 118	Continued From page 20 #3's medications revealed: -Trazodone 50 mg - 1 tablet at HS. -Latuda 40 mg - 1 tablet at HS. -Metformin HCL 500 mg - 1/2 tablet 2 times a day. -Lithium Carbonate ER 450 mg - 2 tablets at HS. -Topiramate 100 mg - 1/2 tablet every a.m., 1 tablet at HS. -Gabapentin 300 mg - 1 capsule 3 times a day for pain. -Levothyroxine 25 mcg (micrograms) 1 tablet every day. -Hydroxyzine HCL 25 mg - 1 - 2 tablets every 6 hours PRN. -Hydroxyzine PAM 25 mg - 1-2 capsules every 6 hours PRN for anxiety. Review on 7/7/21/22 of Client #3's physician orders revealed: -5/31/22 - Client able to self-administer her medications. -7/5/22 - Trazodone 50 mg - 1 tablet at HS; Latuda 40 mg - 1 tablet at HS; Metformin HCL 500 mg - 1/2 tablet 2 times a day; Lithium Carbonate ER 450 mg - 2 tablets at HS; Topiramate 100 mg - 1/2 tablet every a.m., 1 tablet at HS; Gabapentin 300 mg - 1 capsule 3 times a day for pain; Levothyroxine 25 mcg (micrograms) 1 tablet every day; Hydroxyzine HCL 25 mg - 1 - 2 tablets every 6 hours PRN; Hydroxyzine PAM 25 mg - 1-2 capsules every 6 hours PRN for anxiety. Interview on 7/27/22 with the Housing Manager revealed: -She was a Behavioral Health Tech, a Medication Aide and a Housing Manager for the sober living house. -They did not keep MARs of the clients' medications since they self-administered their	V 118		

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medications.
-Each client had containers for 7 days of medications.
-They did random pill counts on the clients to ensure they had the correct number of pills based on the day and time of the week.
-She was familiar with what most medications looked like as she had been doing this a long time.
-If a staff member doing a pill count didn't recognize the medication it could always be looked up on the internet by the color/name/number that was on the pill.

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

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.

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27G .1101 Partial Hospitalization - Scope

10A NCAC 27G .1101 SCOPE
A partial hospitalization facility is a day/night facility which provides a broad range of intensive and therapeutic approaches which may include group, individual, occupational, activity and recreational therapies, training in community living and specific coping skills, and medical services as needed primarily for acutely mentally ill individuals. This facility provides services to:
(1) prevent hospitalization; or
(2) to serve as an interim step for those leaving an inpatient hospital.
This facility provides a medical component in a

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less restrictive setting than a hospital or a residential treatment or rehabilitation facility.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide an individual and group Partial Hospitalization Program (PHP) for acutely mentally ill individuals within the scope of the license affecting 4 of 4 audited clients (Clients #1, #2, #3 and #4). The findings are:

Review on 7/20/22 of Client #1's record revealed:
-Admitted 5/30/22.
-Diagnosis of Alcohol Use Disorder, moderate.

Interview on 7/21/22 with Client #1 revealed:
-When she arrived she was in the PHP program and was to see a therapist 2 times a week.
-It was "almost 3 weeks before I met with someone (therapist)."
-Staff were coming to group with no plan about what group was going to be about; "used to be able to choose what group fits best for you, there were multiple therapists."
-The last two hours of group were "a joke."
-They played "jeopardy, bingo, and yoga."
-When the Clinical Director ran groups she "puts on a You Tube video, something related to DBT (Dialectical Behavior Therapy)...here it's like everything applies to everyone."
-She was now seeing her therapist once a week; she didn't feel it was enough 1-1 time.
-They wanted her to do the "bio bed" (biofeedback technique for relaxation) in place of a therapy session; she did not like the "bio bed... you don't interact with anyone."

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-She would prefer an actual therapy session and had expressed this to the Primary Therapist but nothing has happened.
-It was "supposed to be a safe therapeutic environment...."
-Within the first month she arrived, they "...sat down with whoever (staff) and they took a list of all our concerns and said they would take it to higher ups...basically nothing changed...."

Observation and interview with the Clinical Director on 7/22/22 at 12:26 p.m. of bio sound bed revealed:
-A room that had a large black bed with the head of the bed in a raised position.
-The bed was "for sound and healing."
-There was the capability to listen to a "trauma session" if desired.
-It also had the option to take the clients blood pressure before and after the session.

Review on 7/20/22 of Client #2's record revealed:
-Admitted 4/13/22.
-Diagnoses of Autism Spectrum Disorder, Generalized Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Avoidant/Restrictive Food Intake Disorder, Bipolar I Disorder, Borderline Personality Disorder, Unspecified Feeding/Eating Disorder, Panic Disorder, unspecified, and Obsessive-Compulsive and Related Disorder.

Interview on 7/21/22 with Client #2 revealed:
-When she first came she was in the PHP program; now she was in IOP (Intensive Outpatient Program).
-She came to the program "strictly for mental health services;" she did not have a history of substance use.
-The mental health program was "crap."

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-They connected all the groups as one; she had gone to "all the classes for drugs and alcohol; no one knows what dissociations are...was expecting not to explain this; no one knows what Autism is...all they talk about is alcohol and drugs. They don't know anything about trauma."
-They had one therapist who worked with all of the clients; an Intern was here working as an additional therapist.
-Everyone was on the one therapist's caseload; now she was getting less individual therapy.
-She hadn't talked to a therapist in over a week.
-They had a meeting with the Clinical Director (unsure when), the "group was really upset about something, don't remember what, shouting out grievances, we all said this list (of concerns) isn't going anywhere."

Review on 7/20/22 of Client #3's record revealed:
-Admitted 5/29/22.
-Diagnoses of Unspecified Feeding/Eating Disorder, Bipolar II Disorder, PTSD, and Alcohol Use Disorder, moderate.

Interview on 7/20/22 with Client #3 revealed:
-When she first came to the facility she was in the PHP program and now she was in IOP.
-She came to treatment for ED (eating disorder) and SA (substance abuse).
-There was "technically only one therapist for all of us."
-The ED program was "garbage."
-She "can't establish safety here...incredible turnover...clinician being spread so thin...went two weeks without a session..."
-She was asked to do the "bio sound bed" as a replacement for therapy.
-When in group, "...all sitting in there and don't know whose running group...."

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Review on 7/20/22 of Client #4's record revealed:
-Admitted 4/24/22.
-Discharged 7/22/22.
-Diagnoses of Major Depressive Disorder, GAD, PTSD, Opiate Use Disorder, Stimulant Use Disorder, Sedative Use Disorder, Insomnia, Attention-Deficit Hyperactivity Disorder, and Scoliosis.

Interview on 7/21/22 with Client #4 revealed:
-She was in the PHP program and just went to IOP yesterday.
-She had a relapse 3 weeks into the program.
-It was different in the beginning, the program has "fallen apart since then."
-All the therapists "walked out;" this was 3 days after she was admitted.
-She waited 2 weeks to get a therapist.
-Now the Group Facilitator was her assigned therapist; "She's not a natural therapist, [Primary Therapist] is the only therapist."
-The Group Facilitator "didn't really understand my addiction...don't feel she has a background with addiction."
-Sometimes during group she was triggered and would really want to talk about it, but she felt "put off" by the Group Facilitator.
-She had a relapse 3 weeks into the program.
-She felt like all her progress was due to what she had done on her own.
-They were unorganized; there was not set classes or subjects, no matter what program they were in they "all have to do the same thing. They don't make any exceptions."
-On Tuesday the clients with ED were taken out to eat; they made people with SA stay back.
-If the ED group wasn't back yet, there was nothing to do, everyone was falling asleep.
-Usually the Clinical Director would play a video or we would do writing.

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-There was no set topic, "we do the same worksheet over and over, I would color...I could do this at home."
-They had a meeting, she couldn't remember when or with what staff, where they addressed a lot of concerns.
-The concerns included "...therapists walking out...why isn't there more therapists...being unorganized...don't have set classes or subjects...don't have individual therapy...all have to do the same thing. They don't make any exceptions. Waited 2 weeks to get a therapist. [Group Facilitator] wasn't supposed to be my set therapist...."

Review on 7/22/22 of an email correspondence from the Housing Manager dated 6/9/22 titled "QA [Quality Assurance]: Solutions" revealed:
-The recipients addressed were the Clinical Director, the Program Director, and the licensees (3 owners).
-The complaints included:
"1. Facilitator not being present for groups on time...Solution: [Clinical Director] assigned [Primary Therapist] for group for Wednesday.
2. Being here a week and a half and haven't saw a therapist. Solution: As a team we bring everyone up and confirm they are being seen in a timely manner in treatment team meeting...
4. Facilitator not prepared for groups/will leave the middle of group to run copies etc. Solution: All group Facilitators must be prepared for groups prior to groups to avoid them leaving out to do these things...
5. Not learning anything out groups. Solution: Follow curriculum and advise...
9. Clinical Director does not interact with clients and her groups are horrible. Solution: [Clinical Director] will interact more with clients when she gets time.

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10. [Primary Therapist] shows favorites and does two sessions with certain clients...she sees one twice and me once and I really needed to see her. Solution: [Clinical Director] will speak to [Primary Therapist] about keeping clients over and causing them to miss Ubers, she will also speak to her [Primary Therapist] about being consistent with her sessions.
11. Wednesdays are a s**t show as far as hiking and the organization of it. Solution: [Clinical Director] will ask intern if they can go on a hike with [Group Facilitator] - Need help.
12. Too much cross talk and off topic during groups and I can't learn. Solution: Facilitator needs to go over most rules at beginning of every group.
20. Ed Program is horrible, I wasn't aware the dietitian is not on site. Solution: Starting next week the dietitians will be on site on Mondays...."

Review on 7/22/22 of the facility's group schedule for July 2022 revealed:
-8:30 - 9:10 a.m. - same schedule Monday through Friday for the month- "Assertive Community Group - Breakfast"
-Other group topics remained the same throughout the weeks but on different days and times: "Trauma Education...Trauma Process Art Focused...Interpersonal Weekend Process...Acupuncture...DBT skills...Interpersonal Process-Relationships and SLA [Sex and Love Addiction]...Interpersonal Process-Therapeutic Writing...ED Skills and Body Image...Relapse Prevention...Nutritional Skills Building...Meal Process...Meal Outing.
-There were separate lunch groups - ED lunch group and SUD (Substance Use Disorder) lunch group.
-The differences were clients in IOP completed the day at 1:20 p.m.

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-Clients in the PHP continued group until 3:30 p.m. with the same groups for the month: Interpersonal Process - Family Dynamics, Interpersonal Process - Finding Meaning, 12 Step Spirituality, DBT Skills Education, and Movement and Neuroscience.

Interview on 7/25/22 with the Program Director revealed:
-There was no specific staff assigned to PHP and IOP.
-All staff worked both programs.
-The group schedule pertained to both PHP and IOP; there were no breakout sessions, or separate sessions held depending on the clients need.
-There were no specific groups for mental health diagnoses/needs.

Interview on 7/25/22 with the Primary Therapist revealed:
-Her primary role was to perform individual therapy.
-She did group therapy as needed; volunteered to do one group - Healthy Relationships, and occasionally asked to facilitate Family Dynamics and DBT.
-She currently had a case load of 12 clients and consistently had 9 - 11 clients since she was the only therapist.
-Her case load consisted of clients in both PHP and IOP.

Interview on 7/22/22 with the Clinical Director revealed:
-Her main role was to make sure groups were covered, clinicians were present, and supervision with counselors and interns.
-She sometimes ran groups, "DBT skills...it was more education and not therapeutic."

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-It depended on who was available to run groups..."we've been very short..."
-There was not a group strictly for mental health.
-There was currently one client strictly for mental health and she sat in on the SA groups.
-The relapse prevention group was "...only thing really focused on SA...mindfulness learning was about how to let go of things...which is relevant to all."
-She did receive a list of grievances from the Housing Manager.
-The Primary Therapist was to see clients 1 on 1 once a week, and the bio feedback bed 1 time a week.
-If a client didn't like to do the bio bed, "they have the option of doing an activity, like a relaxation tape or coloring...if the counselor has time she will do a second therapy with them..."

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 172 — 27G .1102 Partial Hospitalization - Staff — V 172

10A NCAC 27G .1102 STAFF
(a) Staff shall include at least one qualified mental health professional.
(b) Each facility serving minors shall have:
(1) a program director who has a minimum of two years experience in child or adolescent services and who has educational preparation in administration, education, social work, nursing, psychology or a related field; and
(2) one staff member present if only one client is in the program, and two staff members present when two or more clients are in the program.

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(c) Each facility shall have a minimum ratio of one staff member present for every six clients at all times.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to have a minimum ratio of one staff member present for every six clients at all times.
The findings are:

Review on 7/20/22 of Client #1's record revealed:
-Admitted 5/30/22.
-Diagnosis of Alcohol Use Disorder, moderate.
-Her first counseling session documented in Clinical Progress notes was 6/13/22.

Review on 7/20/22 of Client #1's BioPsychoSocial assessment dated 5/30/22 revealed:
-She had a history of verbal and physical abuse.
-She had a history of substance abuse.
-"Chief complaint in own words - relapse on alcohol, I need to become financially stable on my own and not be dependent on my parents."

Interview on 7/21/22 with Client #1 revealed:
-When she arrived she was in the PHP program and was to see a therapist 2 times a week.
-It was "almost 3 weeks before I met with someone (therapist)."
-She was now seeing her therapist once a week; she didn't feel it was enough 1-1 time.
-They wanted her to do the "bio bed" (biofeedback technique for relaxation) in place of a therapy session; she did not like the "bio bed... you don't interact with anyone."
-She would prefer an actual therapy session and

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had expressed this to the Primary Therapist but nothing has happened.

Observation and interview with the Clinical Director on 7/22/22 at 12:26 p.m. of bio sound bed revealed:
-A room that had a large black bed with the head of the bed in a raised position.
-The bed was "for sound and healing."
-There was the capability to listen to a "trauma session" if desired.
-It also had the option to take the clients blood pressure before and after the session.

Review on 7/20/22 of Client #2's record revealed:
-Admitted 4/13/22.
-Diagnoses of Autism Spectrum Disorder, Generalized Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Avoidant/Restrictive Food Intake Disorder, Bipolar I Disorder, Borderline Personality Disorder, Unspecified Feeding/Eating Disorder, Panic Disorder, unspecified, and Obsessive-Compulsive and Related Disorder.
-Her first counseling session documented in Clinical Progress notes was 4/22/22.
-Her most recent session was 7/12/22.

Review on 7/20/22 of Client #2's BioPsychoSocial assessment dated 4/13/22 revealed:
-Her goals were to gain independence and self-regulation skills.
-She had a history of physical and sexual abuse and "no healthy way to process" what happened to her.
-"PHP (Partial Hospitalization Program) to build her arsenal of self-regulations tools and begin working on her eating disorder behavior that has not been treated."

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Interview on 7/21/22 with Client #2 revealed:
-When she first came she was in the PHP program; now she was in IOP (Intensive Outpatient Program).
-They had one therapist who worked with all of the clients; an Intern was here working as an additional therapist.
-Everyone was on the one therapist's caseload; now she was getting less individual therapy.
-She hadn't talked to a therapist in over a week.

Review on 7/20/22 of Client #3's record revealed:
-Admitted 5/29/22.
-Diagnoses of Unspecified Feeding/Eating Disorder, Bipolar II Disorder, PTSD, and Alcohol Use Disorder, moderate.
-The first 4 weeks of treatment she saw her therapist once a week (6/1/22, 6/10/22, 6/17/22, and 6/20/22); instead of twice a week.

Review on 7/20/22 of Client #3's BioPsychoSocial assessment dated 5/30/22 revealed:
-Her mother and father had passed away.
-She had an extensive history of substance abuse.
-She recently gained/lost significant amount of weight.
-Her self-esteem was connected to her weight and she had a history of treatment for eating disorder.
-Her short-term goals were to create a sober support system, make new friends, attend meetings, get on her feet and become more stabilized.
-Her long-term goals were to finish 12-step program, have a serious relationship, go back to school, and move out of town.

Interview on 7/20/22 with Client #3 revealed:

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-When she first came to the facility she was in the PHP program and now she was in IOP.
-She came to treatment for ED (eating disorder) and SA (substance abuse).
-There was "technically only one therapist for all of us."
-She "can't establish safety here...incredible turnover...clinician being spread so thin...went two weeks without a session..."
-She was asked to do the "bio sound bed" as a replacement for therapy.

Review on 7/20/22 of Client #4's record revealed:
-Admitted 4/24/22.
-Discharged 7/22/22.
-Diagnoses of Major Depressive Disorder, GAD, PTSD, Opiate Use Disorder, Stimulant Use Disorder, Sedative Use Disorder, Insomnia, Attention-Deficit Hyperactivity Disorder, and Scoliosis.
-Her first counseling session was 4/29/22.
-She had one counseling session a week up to 5/24/22.
-There were 2 weeks between her last session on 5/24/22 until her next session on 6/17/22.
-There was 1 week between 6/21/22 session and her next session on 7/5/22.
-She had a relapse 3 weeks into the program.

Review on 7/20/22 of Client #4's BioPsychoSocial assessment dated 4/25/22 revealed:
-She had a history of childhood trauma, physical abuse, sexual, and emotional abuse.
-She was extremely insecure, didn't know how to make friends or build a sober community
-Childhood trauma led to extensive substance use.
-Her goals for treatment were to stay sober, work on self-worth, make money and save, work on trauma, and ..."resolve unresolved problems I

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have."

Interview on 7/21/22 with Client #4 revealed:
-She was in the PHP program and just went to IOP yesterday.
-All the therapists "walked out;" this was 3 days after she was admitted.
-She waited 2 weeks to get a therapist.
-Now the Group Facilitator was her assigned therapist; "She's not a natural therapist, [Primary Therapist] is the only therapist."
-Sometimes during group she was triggered and would really want to talk about it, but she felt "put off" by the Group Facilitator.

Review on 7/22/22 of the Primary Therapist job duties (undated) revealed:
-Title: Primary Mental Health Counselor.
-"ESSENTIAL FUNCTIONS AND JOB DUTIES: Provides services with adults through individual, group, and family therapy services.
-All clients must have 1 weekly individual session where their therapists work on an objective in their treatment plan.
-All PHP clients are required to have an additional individual weekly which can be any of the following: one on one individual, Biofeedback session, or family session by any licensed clinician."

Interview on 7/25/22 with the Primary Therapist revealed:
-Her primary role was to perform individual therapy.
-She did group therapy as needed.
-She considered her BioPsychoSocial assessment as her first counseling session.
-She currently had a case load of 12 clients and consistently had 9 - 11 clients since she was the only therapist.

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-Her case load consisted of clients in both PHP and IOP.

Interview on 7/25/22 with the Group Facilitator revealed:
-Her primary job was group facilitator; she ran eight groups throughout the week.
-She had 2 clients on her caseload, one of which was just discharged on Friday (7/22/22).
-She wanted to help with continuity of care so she kept a small caseload so clients didn't have to go from counselor to counselor.
-She had the credentials to be a primary therapist, but it was her choice to not do this and to be a Group Facilitator only.
-She was responsible to do Adventure Therapy (go on outings) with the clients.
-She typically did not have any other staff with her when she took the clients on outings.

Interview on 7/22/22 with the Clinical Director revealed:
-Her main role was to make sure groups were covered, clinicians were present, and supervision with counselors and interns.
-It depended on who was available to run groups..."we've been very short..."
-The Primary Therapist was to see the clients 1 on 1 once a week, and the bio sound bed 1 time a week.
-If a client didn't like to do the bio bed, "they have the option of doing an activity, like a relaxation tape or coloring...if the counselor has time she will do a second therapy with them..."
-She did not carry a caseload.

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.

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V 266	27G .4401 Sub. Abuse Intensive Outpt - Scope	V 266		

10A NCAC 27G .4401 SCOPE
(a) A substance abuse intensive outpatient program (SAIOP) is one that provides structured individual and group addiction treatment and services that are provided in an outpatient setting designed to assist adults or adolescents with a primary substance-related diagnosis to begin recovery and learn skills for recovery maintenance.
(b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse and other homogenous groups.
(c) Each SAIOP shall have a structured program, which includes the following services:
(1) individual counseling;
(2) group counseling;
(3) family counseling;
(4) strategies for relapse prevention, which incorporate community and social supports;
(5) life skills;
(6) crisis contingency planning;
(7) disease management;
(8) service coordination activities; and
(9) biochemical assays to identify recent drug use (e.g. urine drug screens).

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide a structured individual and group

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V 266	Continued From page 37 Substance Abuse Intensive Outpatient Program (SAIOP) to assist adults whose primary diagnosis was substance-related within the scope of the license. The findings are: Review on 7/20/22 of Client #1's record revealed: -Admitted 5/30/22. -Diagnosis of Alcohol Use Disorder, moderate. Interview on 7/21/22 with Client #1 revealed: -When she arrived she was in the PHP program and was to see a therapist 2 times a week. -It was "almost 3 weeks before I met with someone (therapist)." -Staff were coming to group with no plan about what group was going to be about; "used to be able to choose what group fits best for you, there were multiple therapists." -The last two hours of group were "a joke." -They played "jeopardy, bingo, and yoga." -When the Clinical Director ran groups she "puts on a You Tube video, something related to DBT (Dialectical Behavior Therapy)...here it's like everything applies to everyone." -She was now seeing her therapist once a week; she didn't feel it was enough 1-1 time. -They wanted her to do the "bio bed" (biofeedback technique for relaxation) in place of a therapy session; she did not like the "bio bed... you don't interact with anyone." -She would prefer an actual therapy session and had expressed this to the Primary Therapist but nothing has happened. -It was "supposed to be a safe therapeutic environment...." -Within the first month she arrived, they "...sat down with whoever (staff) and they took a list of all our concerns and said they would take it to higher ups...basically nothing changed...."	V 266		

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Observation and interview with the Clinical Director on 7/22/22 at 12:26 p.m. of bio sound bed revealed:
-A room that had a large black bed with the head of the bed in a raised position.
-The bed was "for sound and healing."
-There was the capability to listen to a "trauma session" if desired.
-It also had the option to take the clients blood pressure before and after the session.

Review on 7/20/22 of Client #2's record revealed:
-Admitted 4/13/22.
-Diagnoses of Autism Spectrum Disorder, Generalized Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Avoidant/Restrictive Food Intake Disorder, Bipolar I Disorder, Borderline Personality Disorder, Unspecified Feeding/Eating Disorder, Panic Disorder, unspecified, and Obsessive-Compulsive and Related Disorder.

Interview on 7/21/22 with Client #2 revealed:
-When she first came she was in the PHP program; now she was in IOP (Intensive Outpatient Program).
-She came to the program "strictly for mental health services;" she did not have a history of substance use.
-The mental health program was "crap."
-They connected all the groups as one; she had gone to "all the classes for drugs and alcohol; no one knows what dissociations are...was expecting not to explain this; no one knows what Autism is...all they talk about is alcohol and drugs. They don't know anything about trauma."
-They had one therapist who worked with all of the clients; an Intern was here working as an additional therapist.
-Everyone was on the one therapist's caseload;

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now she was getting less individual therapy.
-She hadn't talked to a therapist in over a week.
-They had a meeting with the Clinical Director (unsure when), the "group was really upset about something, don't remember what, shouting out grievances, we all said this list (of concerns) isn't going anywhere."

Review on 7/20/22 of Client #3's record revealed:
-Admitted 5/29/22.
-Diagnoses of Unspecified Feeding/Eating Disorder, Bipolar II Disorder, PTSD, and Alcohol Use Disorder, moderate.

Interview on 7/20/22 with Client #3 revealed:
-When she first came to the facility she was in the PHP program and now she was in IOP.
-She came to treatment for ED (eating disorder) and SA (substance abuse).
-There was "technically only one therapist for all of us."
-The ED program was "garbage."
-She "can't establish safety here...incredible turnover...clinician being spread so thin...went two weeks without a session..."
-She was asked to do the "bio sound bed" as a replacement for therapy.
-When in group, "...all sitting in there and don't know whose running group...."

Review on 7/20/22 of Client #4's record revealed:
-Admitted 4/24/22.
-Discharged 7/22/22.
-Diagnoses of Major Depressive Disorder, GAD, PTSD, Opiate Use Disorder, Stimulant Use Disorder, Sedative Use Disorder, Insomnia, Attention-Deficit Hyperactivity Disorder, and Scoliosis.

Interview on 7/21/22 with Client #4 revealed:

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V 266	Continued From page 40 -She was in the PHP program and just went to IOP yesterday. -She had a relapse 3 weeks into the program. -It was different in the beginning, the program has "fallen apart since then." -All the therapists "walked out;" this was 3 days after she was admitted. -She waited 2 weeks to get a therapist. -Now the Group Facilitator was her assigned therapist; "She's not a natural therapist, [Primary Therapist] is the only therapist." -The Group Facilitator "didn't really understand my addiction...don't feel she has a background with addiction." -Sometimes during group she was triggered and would really want to talk about it, but she felt "put off" by the Group Facilitator. -She had a relapse 3 weeks into the program. -She felt like all her progress was due to what she had done on her own. -They were unorganized; there was not set classes or subjects, no matter what program they were in they "all have to do the same thing. They don't make any exceptions." -On Tuesday the clients with ED were taken out to eat; they made people with SA stay back. -If the ED group wasn't back yet, there was nothing to do, everyone was falling asleep. -Usually the Clinical Director would play a video or we would do writing. -There was no set topic, "we do the same worksheet over and over, I would color...I could do this at home." -They had a meeting, she couldn't remember when or with what staff, where they addressed a lot of concerns. -The concerns included "...therapists walking out...why isn't there more therapists...being unorganized...don't have set classes or subjects...don't have individual therapy...all have	V 266		

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V 266	Continued From page 41 to do the same thing. They don't make any exceptions. Waited 2 weeks to get a therapist. [Group Facilitator] wasn't supposed to be my set therapist...." Review on 7/22/22 of an email correspondence from the Housing Manager dated 6/9/22 titled "QA [Quality Assurance]: Solutions" revealed: -The recipients addressed were the Clinical Director, the Program Director, and the licensees (3 owners). -The complaints included: "1. Facilitator not being present for groups on time...Solution: [Clinical Director] assigned [Primary Therapist] for group for Wednesday. 2. Being here a week and a half and haven't saw a therapist. Solution: As a team we bring everyone up and confirm they are being seen in a timely manner in treatment team meeting... 4. Facilitator not prepared for groups/will leave the middle of group to run copies etc. Solution: All group Facilitators must be prepared for groups prior to groups to avoid them leaving out to do these things... 5. Not learning anything out groups. Solution: Follow curriculum and advise... 9. Clinical Director does not interact with clients and her groups are horrible. Solution: [Clinical Director] will interact more with clients when she gets time. 10. [Primary Therapist] shows favorites and does two sessions with certain clients...she sees one twice and me once and I really needed to see her. Solution: [Clinical Director] will speak to [Primary Therapist] about keeping clients over and causing them to miss Ubers, she will also speak to her [Primary Therapist] about being consistent with her sessions. 11. Wednesdays are a s**t show as far as hiking and the organization of it. Solution: [Clinical	V 266		

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Director] will ask intern if they can go on a hike with [Group Facilitator] - Need help.
12. Too much cross talk and off topic during groups and I can't learn. Solution: Facilitator needs to go over most rules at beginning of every group.
20. Ed Program is horrible, I wasn't aware the dietitian is not on site. Solution: Starting next week the dietitians will be on site on Mondays...."

Review on 7/22/22 of the facility's group schedule for July 2022 revealed:
-8:30 - 9:10 a.m. - same schedule Monday through Friday for the month- "Assertive Community Group - Breakfast"
-Other group topics remained the same throughout the weeks but on different days and times: "Trauma Education...Trauma Process Art Focused...Interpersonal Weekend Process...Acupuncture...DBT skills...Interpersonal Process-Relationships and SLA [Sex and Love Addiction]...Interpersonal Process-Therapeutic Writing...ED Skills and Body Image...Relapse Prevention...Nutritional Skills Building...Meal Process...Meal Outing.
-There were separate lunch groups - ED lunch group and SUD (Substance Use Disorder) lunch group.
-The differences were clients in IOP completed the day at 1:20 p.m.
-Clients in the PHP continued group until 3:30 p.m. with the same groups for the month: Interpersonal Process - Family Dynamics, Interpersonal Process - Finding Meaning, 12 Step Spirituality, DBT Skills Education, and Movement and Neuroscience.

Interview on 7/25/22 with the Program Director revealed:
-There was no specific staff assigned to PHP and

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IOP.
-All staff worked both programs.
-The group schedule pertained to both PHP and IOP; there were no breakout sessions, or separate sessions held depending on the clients need.
-There were no specific groups for mental health diagnoses/needs.

Interview on 7/25/22 with the Primary Therapist revealed:
-Her primary role was to perform individual therapy.
-She did group therapy as needed; volunteered to do one group - Healthy Relationships, and occasionally asked to facilitate Family Dynamics and DBT.
-She currently had a case load of 12 clients and consistently had 9 - 11 clients since she was the only therapist.
-Her case load consisted of clients in both PHP and IOP.

Interview on 7/22/22 with the Clinical Director revealed:
-Her main role was to make sure groups were covered, clinicians were present, and supervision with counselors and interns.
-She sometimes ran groups, "DBT skills...it was more education and not therapeutic."
-It depended on who was available to run groups..."we've been very short..."
-There was not a group strictly for mental health.
-There was currently one client strictly for mental health and she sat in on the SA groups.
-The relapse prevention group was "...only thing really focused on SA...mindfulness learning was about how to let go of things...which is relevant to all."
-She did receive a list of grievances from the

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V 266	Continued From page 44 Housing Manager. -The Primary Therapist was to see clients 1 on 1 once a week, and the bio feedback bed 1 time a week. -If a client didn't like to do the bio bed, "they have the option of doing an activity, like a relaxation tape or coloring...if the counselor has time she will do a second therapy with them..." 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 266		
V 267	27G .4402 Sub. Abuse Intensive Outpt- Staff 10A NCAC 27G .4402 STAFF (a) Each SAIOP shall be under the direction of a Licensed Clinical Addictions Specialist or a Certified Clinical Supervisor who is on site a minimum of 50% of the hours the program is in operation. (b) When a SAIOP serves adult clients there shall be at least one direct care staff who meets the requirements of a Qualified Professional as set forth in 10A NCAC 27G .0104 (18) for every 12 or fewer adult clients. (c) When a SAIOP serves adolescent clients there shall be at least one direct care staff who meets the requirements of a Qualified Professional as set forth in 10A NCAC 27G .0104 (18) for every 6 or fewer adolescent clients. (d) Each SAIOP shall have at least one direct care staff present in the program who is trained in the following areas: (1) alcohol and other drug withdrawal symptoms; and (2) symptoms of secondary complications due to alcoholism and drug addiction.	V 267		

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(e) Each direct care staff shall receive continuing education that includes the following:
(1) understanding of the nature of addiction;
(2) the withdrawal syndrome;
(3) group therapy;
(4) family therapy;
(5) relapse prevention; and
(6) other treatment methodologies.
(f) When a SAIOP serves adolescent clients each direct care staff shall receive training that includes the following:
(1) adolescent development; and
(2) therapeutic techniques for adolescents.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure each direct care staff received continuing education that included understanding the nature of addiction, the withdrawal syndrome, group therapy, family therapy and relapse prevention for 3 of 3 audited staff (Group Facilitator, Primary Therapist and Clinical Director). The findings are:

Review on 7/21/22 of the personnel file for the Group Facilitator revealed:
-Hire date: 3/18/19.
-Licensed Clinical Mental Health Counselor - expiration date 6/30/24.
-Eleven continuing education certificates in 2020.
-There was no recent documented continuing

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education for group/family therapy, nature of addiction, relapse prevention or withdrawal syndrome.

Review on 7/21/22 of the personnel file for the Primary Therapist revealed:
-Hire date: 12/20/21.
-Licensed Clinical Social Worker - Associate - 11/4/23.
-No documented continuing education for group/family therapy, nature of addiction, relapse prevention or withdrawal syndrome.

Review on 7/21/22 and 7/22/22 of the personnel file for the Clinical Director revealed:
-Hire date: 1/12/22.
-Licensed Clinical Addictions Specialist - 12/31/22.
-5/1/22 - "Addiction Interactions: identifying and treating the neuropathways of addiction."
-4/13/22 - "Workplace Violence - contributing factors or causes of threatening behavior."
-No documented continuing education for group/family therapy, relapse prevention or withdrawal syndrome.

Interview on 7/21/22 with the Program Director revealed:
-The staff should be sending her copies of their certificates when they completed a training.
-She would ask staff for them.

Interview on 7/25/22 with the Group Facilitator revealed:
-The individual she gave her continuing education certificates to no longer worked at the facility.
-She was unsure what trainings she had been to recently; she didn't always do trainings in addiction.
-Her "focus has been more trauma related."

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V 267	Continued From page 47 -She did not have any more recent certificates she could provide surveyor. Interview on 7/25/22 with the Primary Therapist revealed: -She had completed about 24 continuing education units since being employed at the facility. -She did not have any certificates she could send to review. Interview on 7/22/22 with the Clinical Director revealed: -She did not have any more continuing education certificates than what was provided. 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 267		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.	V 536		

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V 536	Continued From page 48 (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and	V 536		

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(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee

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performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(l) Documentation shall be the same preparation as for trainers.

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This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to ensure staff completed an initial training in the use of alternatives to restrictive interventions for 2 of 3 staff (Clinical Director and Primary Therapist) and failed to ensure 1 of 3 staff (Group Facilitator) completed an annual refresher course. The findings are:

Review on 7/21/22 of the personnel file for the Group Facilitator revealed:
-Hire date: 3/18/19.
-NCI (Nonviolent Crisis Intervention) plus 11/2/20 - expired 11/1/21.

Review on 7/21/22 of the personnel file for the Primary Therapist revealed:
-Hire date: 12/20/21.
-No documentation of alternatives to restrictive interventions.

Review on 7/21/22 and 7/22/22 of the personnel file for the Clinical Director revealed:
-Hire date: 1/12/22.
-No documentation of alternatives to restrictive interventions.

Interview on 7/25/22 with the Group Facilitator revealed:
-The person who usually arranged the NCI training no longer worked at the facility.
-She did not realize it had expired.

Interview on 7/25/22 with the Primary Therapist revealed:
-She had NCI training in the past, but not since she had been employed at this facility.

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WILLOW PLACE	**30 GARFIELD STREET, SUITE A ASHEVILLE, NC 28803**

(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 536	Continued From page 52 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 536		