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COASTAL HORIZONS CENTER, INC.	120 COASTAL HORIZONS CENTER DRIVE SHALLOTTE, NC 28470

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V 000	INITIAL COMMENTS An annual survey was completed on September 16, 2022. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G.3300 Outpatient Detoxification for Substance Abuse; 10A NCAC 27G. 3600 Outpatient Opioid Treatment; 10A NCAC 27G.4400 Substance Abuse Intensive Outpatient Program; and, 10A NCAC 27G.4500 Substance Abuse Comprehensive Outpatient Treatment. This facility has a current census of 76. The survey sample consisted of audits of 5 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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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the legal scope of practice for licensed nurses. The findings are:

Review on 9/15/22 of the Licensed Practical Nurse's (LPN) personnel file revealed:
-LPN hire date was 6/15/21.
-LPN signed her job description entitled, "Substance Abuse Nurse," on 4/19/21.

Review on 9/15/22 of the Registered Nurse's (RN) personnel file revealed:
-RN hire date was 2/14/22.
-RN signed her job description entitled, "Substance Abuse Nurse," on 4/28/22.

Review on 9/15/22 of the facility job description, "Substance Abuse Nurse," revealed:
-The same job description was signed by the RN and the LPN.
-Requirements included the "Ability to work independently and knowledgeable of when to make an appropriate referral."
-Job duties included, "Dispenses narcotic treatment medication, assesses clients and documents clinical and medical findings relevant to treatment ..."

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V 105	Continued From page 3 Review on 9/15/22 of the North Carolina Board of Nursing and the North Carolina State Opioid Treatment Authority, "Joint Statement on Nursing Scope of Practice in North Carolina Licensed Opioid Treatment Programs (OTPs)" effective 1/27/14 revealed: -LPN practice was not independent in any setting, including OTPs. -Assessments and judgements made by LPNs in the initial induction phase of care exceed LPN Scope of Practice. -Dispensing of medications was beyond the legal scope of practice for both RNs and LPNs. -Recommendations supportive of the Scope of Practice in OTPS included the following: -"Programs should develop and implement separate job descriptions for RNs and LPNs..." -"Programs should eliminate the term 'dispenses' medication from RN and LPN job descriptions, and instead, use the term 'supplies' medication, or use the phrase 'supplies and administers' medication." Review on 9/15/22 of the North Carolina Board of Nursing "LPN Scope of Practice - Clarification Position Statement for LPN Practice" dated 2014 revealed, "The LPN within scope of practice participates in any assessment process, if permitted by agency policy, using structured written guidelines, policies, and forms that outline the data to be obtained." Review on 9/15/22 of written facility guidelines, policies and forms for the nursing assessment revealed there was no written policy, procedure, or form for the LPN to follow during participation in the assessment process. Interview on 9/13/22 the LPN stated: -She began working at the clinic in 2021.	V 105		

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V 105	Continued From page 4 -She administered medications and prepared take home medications. -She did a "visual assessment" of clients when they presented for medication administration. -For clients in the induction phase she would ask them how they were "doing." -She would document a note if something "significant" was identified. -She did not always document a note if the client responded they were "ok." Interview on 9/16/22 the RN stated: -Her role was to complete the admission intake process by completing an assessment and obtaining client consents. -She would "fill in" for the LPN to administer medications if needed. -At the dosing window nurses looked for signs of sedation. -If there were concerns there was a provider to contact on site. Interviews on 9/13/22 - 9/15/22 the Director of Nursing (DON) stated: -The nurse at the dosing window did a daily assessment when a client was in the induction phase. -It was her understanding that induction was the first 2 weeks of dosing. -The nurses did not have a structured assessment tool to follow and document their assessment. -The nurse would ask questions like "how are you doing ... how long is your dose lasting .... how are you sleeping ... how is your anxiety ... are you having sweats or chills." -The nurse would observe for symptoms of withdrawal such as any sweating. -The nurses did not have a set script of assessment questions to ask clients when doing	V 105		

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V 105	Continued From page 5 their daily assessments.	V 105		
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 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.	V 233		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide services designed to affect constructive changes in the client's lifestyle by using methadone in conjunction with the provision of rehabilitation and medical services affecting 1 of 5 audited clients (#1). The findings are:

Review on 9/13/22 of client #1's record revealed:
-44-year-old female admitted 10/13/21.
-Diagnoses of opioid disorder, tobacco use disorder, cocaine use disorder, general anxiety disorder, and alcohol use disorder.
-Client #1 received Subutex from 10/13/21 until 5/11/22 for treatment of opioid use disorder.
-5/11/22: Physician Assistant (PA) documented:
-Client #1's medications included quetiapine, 50 milligram (mg) tablet- 1 tablet by mouth at bedtime; fluoxetine, 20 mg capsule - 3 capsules by mouth once a day; methadone, 5mg/ 5ml (milliliter) solution.
-Client #1's UDS (urine drug screen) was positive for amphetamines, cocaine, alcohol, buprenorphine and methadone.
-PA changed client #1 from Subutex 24 mg to methadone at 60 mg and titrate up by 10 mg a day until she reached a daily dose of 90 mg.
-" ...I will have her stop dose tomorrow and screened prior to dosing."
-Re-evaluate client in 1 week.
-5/12/22: No documentation a UDS was performed. Client #1 received methadone 70 mg.
-5/13/22: UDS performed and was positive for alcohol, cocaine, amphetamines, buprenorphine and methadone. No documentation the PA was informed of results. Client #1 received methadone 80 mg at the facility and supplied with 2 take home doses of 90 mg each.
-5/16/22 and 5/17/22 client #1 received 90 mg of

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V 233	Continued From page 7 methadone at the facility and attended her SACOT (Substance Abuse Comprehensive Outpatient Treatment) group. -5/18/22 client #1 was absent. -5/19/22 client #1 presented to the facility with her mother and observed by Counselor #2 to be incoherent and unsteady. A UDS was done and was positive for cocaine, buprenorphine and methadone. Counselor #2 "urged" the client to go to the hospital. -No documentation client #1 was assessed by a physician, PA, or nurse between 5/12/22 and 5/19/22. -5/19/22-5/22/22 client #1 was hospitalized for substance-induced psychosis with acute encephalopathy. Review on 9/15/22 of client #1's Comprehensive Clinical Assessment (CCA) dated 5/13/22 revealed: -"Presenting Problem: CCA Update 5/13/2022: Client is being reassessed today due to having positive screens after completing IOP (Intensive Outpatient Program)." -Client #1 reported she relapsed on 4/21/22 with cocaine, and then followed with the other substances. -Client #1 reported her last use of alcohol, cocaine, and methamphetamine was on 5/8/22. -Recommended client #1 attend SACOT. -"The client needs to be considered for residential placement to provide the client a supportive environment where she can begin to abstain from illicit substances and utilize supports, if recovery and abstination cannot be achieved." Review on 9/15/22 of requested counselor notes for client #1 revealed individual client notes were included with notes about that day's SACOT group meeting.	V 233		

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V 233	Continued From page 8 Review on 9/15/22 of client #1's 5/16/22 SACOT note documented by Counselor #2 revealed: -Client #1 reported that she switched to methadone from Subutex. -Client #1 stated the methadone was causing her "drowsiness." -No documentation the counselor referred client #1 to a nurse or provider for evaluation. Review on 9/15/22 of client #1's 5/17/22 SACOT note documented by Counselor #2 revealed: -"Client (client #1) reported that she believes her methadone dosage is too high and that it is causing her significant drowsiness. Client struggled to remain alert during group." -No documentation the counselor referred client #1 to a nurse or provider for evaluation. Review on 9/15/22 of medical assistant note dated 5/18/22 revealed: -"Pt's (patient's) mother called and stated that [client #1] was not herself and her medications needed to be changed back to what they were. Mom said that she was sleeping and she did not wake her up to come dose because she had not been sleeping and she felt she needed to. I told her I did not have a signed consent for me to talk to her and so [client #1] would need to sign one the next time she comes in." -No documentation the medical assistant reported the phone call to the counselor, nurse, or provider. Review on 9/15/22 of Counselor #2's note dated 5/19/22 revealed: -"Clinician ran into client (client #1) in the hallway as client was arriving to dose. Client was guided by her mother as client appeared unstable in her walking. Client was not wearing shoes. Client	V 233		

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V 233	Continued From page 9 appeared to be in significant distress. Client then produced UDS per CH (Coastal Horizons) request. Client's UDS was positive for cocaine, methadone, and buprenorphine. Client explained that she feels strange. Client became tearful and stated that she did not know what was going on. Client's speech was slurred and some of her speech was incoherent. Client's mother reported that the client did not leave her bed on Tuesday after SACOT. Client's mother reported that the client appeared to be in a daze and was walking around the home naked but unaware of what she was doing. Clinician urged client to seek medical attention at the hospital. Client and client's mother confirmed that they were going to head to the hospital directly from CH (Coastal Horizons)." -No documentation the counselor referred client #1 to a nurse or medical provider for evaluation. Review on 9/15/22 of client #1's hospital record for admission 5/19/22 - 5/22/22 revealed: -"44 yo (year-old) female who was on suboxone was switched to methadone this week at Coastal Horizons. She received methadone on 5/17 and has not been acting normally since. Mom states she has been out of it, mumbling, confused, possibly hallucinating. Mom did not take her for dose yesterday due to these sx (symptoms)." -"Chief Complaint - Altered Mental Status - pt (patient) reports feeling 'out of it' for one week. States she been unable to eat since Tuesday ...Pt reportedly takes Methadone and dose was changed but she has not had any since Tuesday." -"Review of Systems - Psychiatric/Behavioral: Positive for confusion, dysphoric mood and hallucinations." "Physical Exam- Psychiatric: Low slow pressured rambling speech, grooming and hygiene ok, possibly responding to internal stimuli." -"Diagnosis management comments: Pt became	V 233		

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increasingly alert and agitated during her evaluation to the point of ripping IV (intravenous) out, walking around naked, becoming loud and verbally aggressive with staff required Haldol, Benadryl, Ativan IM (intramuscular) and security presence to redirect ...UDS + for cocaine."
-5/22/22 Discharge Diagnosis:
Substance-induced psychosis with acute encephalopathy. "Her initial psychosis was felt related to cocaine use ..."

Review on 9/15/22 of client #1's dosing history from 5/23/22- 9/15/22 revealed:
-5/23/22: Client #1 returned to the facility following discharge from the hospital on 5/22/22.
-Client #1 received methadone 30 mg on 5/23/22 and 5/24/22 per standing order to decrease 75% after an absence between 5-14 days.
-No nursing or medical assessment documented on 5/23/22 or 5/24/22.

Review on 9/15/22 of client #1's PA evaluation and management note dated 5/25/22 revealed:
-"A few days after her induction onto methadone she ended up going to the hospital. She does not really remember the events around that time. She ended up missing several doses during this time."
-"Recommendation: 1. Will continue patient on methadone. I will titrate her up to 40 mg today."

Interview on 9/15/22 Counselor #2 stated:
-She had been employed since May 2021 and she facilitated the SACOT group that met 5 days a week.
-She was the Outpatient Opioid Treatment (OOT) program counselor for all members of the SACOT group that were receiving OOT services.
-SACOT clients were "high risk" clients.
-Client #1 was attending SACOT because she

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had relapsed and her first day back was on 5/16/22.
-Counselor #2 knew client #1 had switched from Subutex to methadone.
-Client #1 reported the methadone made her a "little tired" and she was struggling to stay awake.
-Counselor #2 observed client #1's eyes were fluttering as she tried to stay awake during group.
-In most situations she would make her supervisor and the provider aware of her observations.
-When it came to medications she would not get "too involved" because it was "out of her scope."
-She reported her observations of client #1 to the PA and her Supervisor, but did not document these reports.
-The PA responded that he was going to meet with the client.

Interview on 9/16/22 the Registered Nurse (RN) stated:
-In her role she completed the admission nursing assessments, obtained consents for new admissions, and would "fill in" for the Licensed Practical Nurse (LPN) as needed for medication administration.
-She did not recall anything about client #1 between 5/11/22 and 5/17/22 when she was listed as the dosing nurse .
-The "Case Notes" she signed on 5/17/22 were a weekly "service" note and did not reflect a nursing assessment. These notes were typically entered by the LPN, and were pre-populated to read, "No problems or concerns..." The only thing the nurse would change to the pre-populated text was a note about a client's "absent days" during the week.
-The RN was always available to do a physical assessment if needed.
-She had recently become aware of the need for

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better communication between staff about dosage changes.
-Until recently nurses never checked results of UDS.
-She believed it was on 9/2/22 that she learned a patient told the physician he was drinking alcohol daily and he had frequently tested positive for alcohol. "We really should have known and had orders to do random breathalyzers."
-After becoming aware of this case, she had begun doing breathalyzers during the admission process, reviewing UDS results, and would put a "flag" in a client record to perform a breathalyzer if the client tested positive for alcohol.
-There was no standing order for when breathalyzers should be done by the nurse.
-The nurses needed to be informed by the counselors about changes with the clients, such as if the counselor sent a client to the hospital, or found out the client was pregnant.
-The nurse may find out "days later" that a client went to the hospital or was incarcerated.
-Communication had improved but was a "work in progress."

Interview on 9/14/22 the Director of Nursing (DON) stated:
-There was no written structure, guideline, or form for the nurse to use to assess clients at the dosing window.
-There was a nursing assessment form for a "full blown" nursing assessment if requested.
-The nurses had "taken it upon themselves" to develop a list of positive UDS results to track and review with provider at the "emergent" time, i.e. if a client was impaired.
-This list had been in place for approximately 2 weeks.

Interview on 9/14/22 the PA stated:

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COASTAL HORIZONS CENTER, INC.	120 COASTAL HORIZONS CENTER DRIVE SHALLOTTE, NC 28470

(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 233	Continued From page 13	V 233		

-The OTP clients attended groups and were observed by multiple staff, all trained to note if a client was showing signs of overdose.
-He did not recall anyone telling him client #1 was showing signs of being over medicated after he changed her from Subutex to methadone (5/11/22).
-He was not sure if there was a protocol to address a positive UDS for alcohol.
-If he had been aware client #1 was showing signs of drowsiness he would have "likely" stopped dosing her.

Interview on 9/14/22 the Program Director stated everyone had access to UDS results, but no one had been designated to review and follow up on positive UDS results with consideration of the client's dosing orders.

Interview on 9/15/22 the Medical Director stated:
-"You can't switch someone from Subutex to methadone at 60 mg... It doesn't work that way."
-Because client #1 had a positive UDS for alcohol and was on other psychotropic medications, and other substances, she should have started methadone at a much lower dose, i.e. 25 mg, and not "raised anymore than 5 mg every other day."
-The providers could not see every patient every day, so if any staff observed a patient showing symptoms that indicated they should not be dosing, the staff should call the provider.
-If the provider knew a client tested positive for alcohol, the provider would usually require a breathalyzer test before subsequent dosing. If the breathalyzer was positive, the provider would usually "hold" their order.
-Alcohol and methadone were suppressants, and it had been his experience that clients who mix the two would sometimes use cocaine or other similar substances, to "level off" and to try to stay

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL010-071	A. BUILDING: _____ B. WING _____	09/16/2022

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V 233	Continued From page 14 awake. -Reviewing client #2's record, this would be a patient he would typically recommend they go to a higher level of care and "get under control." -He had not been made aware prior to 9/14/22 of any issues related to client #1's switch from Subutex to methadone on 5/11/22. Review on 9/16/22 of the Plan of Protection dated 9/16/22 completed by the Quality Improvement Training Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? We will ensure coordination of care between all relevant medical staff and document same. We will pursue additional medical guidance on protocols for transitions between medications. -Describe your plans to make sure the above happens. Use our existing meetings to reinforce this action and to review cases where transitions take place. We will use our consultation with the state's medical experts." Client #1 was admitted on 10/21/21 with diagnoses of opioid use disorder, alcohol use disorder, cocaine use disorder, tobacco use disorder, and general anxiety disorder. Client #1 relapsed and was changed from Subutex 24 mg to methadone 60 mg on 5/11/22 with orders to increase her dose by 10 mg daily until she reached 90 mg. The PA ordered for the client to have another UDS on 5/12/22 prior to dosing. The next UDS was done 5/13/22 and found to be positive for alcohol, cocaine, and amphetamines. On 5/16/22 and 5/17/22 client #1 reported and exhibited symptoms consistent with over-medication. She was absent on 5/18/22, and referred by the counselor to the hospital on 5/19/22 when she appeared incoherent and unstable and had a positive UDS for cocaine.	V 233		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 233	Continued From page 15 Between 5/12/22 and 5/19/22 client #1 was titrated up from 60 mg to 90 mg of methadone with no nursing assessments documented. It was not a practice for the nursing staff to review UDS results and client #1's take home doses for 5/14/22 and 5/15/22 were increased to 90 mg. There was no documentation by any staff that the reports by the client, the client's mother, the positive UDS's on 5/13/22 and 5/19/22, or staff observations of client #1 on 5/16/22, 5/17/22, or 5/19/22 were reported to the on site medical staff. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $6,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 233		