	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:				
		MHL032-412	B. WING			R 21/2022	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
BAART	COMMUNITY HEALTH		TH MANGUM	STREET, SUITE 300 & 400			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
V 000	INITIAL COMMEN	TS	V 000				
		w up survey was completed 2022. Deficiencies were cited.					
	categories: 10A NCAC 27G .36 Treatment 10A NCAC 27G. 44 Intensive Outpatien 10A NCAC 27G. 45	sed for the following service 600 Outpatient Opioid 400 Substance Abuse at Program 500 Substance Abuse utpatient Treatment Program					
		urrent census of 407. The sisted of audits of 18 current ased clients.					
V 235	10A NCAC 27G .36 (a) A minimum of c counselor or certifie to each 50 clients a on the staff of the fa this prescribed ratic individual who is ce unavailability of cer hiring area, then it r person, provided th certification require months from the da (b) Each facility sh member on duty tra (1) drug abus (2) symptoms to drug addiction. (c) Each direct car	one certified drug abuse ed substance abuse counselor and increment thereof shall be acility. If the facility falls below b, and is unable to employ an ertified because of the tified persons in the facility's may employ an uncertified nat this employee meets the ments within a maximum of 26					

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If continuation sheet 1 of 15



	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		`	X3) DATE S COMPL	
		DENTIFICATION NOMBER.	A. BUILDING	G:		
		MHL032-412	B. WING		R <b>09/21</b>	/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
BAART (			TH MANGU I, NC 27701	M STREET, SUITE 300 & 400		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLE DATE
V 235	Continued From pa	ge 1	V 235			
	(3) group and	awal syndrome; I family therapy; and diseases including HIV, I diseases and TB.				
	facility failed to have drug abuse counse	et as evidenced by: view and interviews, the e a minimum of one certified lor or certified substance each 50 clients. The findings		BAART Programs Durham is actively recruiting for two additional counselors in ord comply with rule 27G .3603. BAART utilizes a recruiting platform called JobVite for position posting, application processing, can review and messaging, offer letters, and onbo paperwork. The program Treatment Center D and Counselor Supervisors have access to th to review candidates and schedule interviews	or didate oarding Directors his site s.	11/20/2
	-The facility had a c	eload of 70 clients. eload of 67 clients. eload of 64 clients. eload of 72 clients.		Additionally, the Regional Director of Operation reviews the JobVite platform to follow up on the recruiting progress and reach out to qualified applicants. The organization has employed a recruiter dedicated specifically to the role of substance abuse counselor to assist in the recruitment and hiring of counselor positions. Regional Director of Operations will reach ou recurring department to set up a weekly call we counselor recruiter, Sr. Talent Recruitment M Regional Director of Operations, and Treatmet Center Directors to explore ways and efficien	the . The It to the with the fanager, ent	
	-Caseload consiste aware that the max state of North Caro -Caseload was ove had a lot of needs. -It was difficult to pr	rwhelming because clients ovide all of the client ' s needs to the lack of additional		targeted towards filling counselor vacancies. Additionally all of the Treatment Center Direc have a weekly call with the Regional Director Operations as a group and a weekly individua where vacancies and progress is discussed in to maximize urgency. BAART Programs Durf periodically offers a Counselor Sign-On and Retention Bonus for various vacancies, and v ensure that there is a sign-on and retention b place for counselors.	otors r of al call in order ham will	

If continuation sheet 2 of 15

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		MHL032-412	B. WING			R 21/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
BAART	COMMUNITY HEALTH		TH MANGUM I, NC 27701	STREET, SUITE 300 & 400		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
V 235	Continued From pa	ge 2	V 235			
	counselor 's absen -It would be feasible caseload of 35 clier -Services could not current caseload.	e to effectively serve a				
	-Employed since Ja -He confirmed his c -Reported the diffic his caseload. -Sessions with clier	anuary 2022. caseload. ulties meeting with clients on				
	Director revealed: -She was aware the above 50. -She just hired a cli -The clinical supervise and supervise the c -Cases would be m caseload to the clin -There were plans the -She found it difficult rate. -She confirmed the	visor would carry a caseload counselors. oved from the counselor's				
V 237	10A NCAC 27G .36 (a) Hours. Each fa days per week, 12 weekend and holida	utpt. Opiod - Operations 04 OPERATIONS acility shall operate at least six months per year. Daily, ay medication dispensing eduled to meet the needs of	V 237			

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	equiation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL032-412	B. WING			R <b>21/2022</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		SADE 800 NOR	TH MANGUM	STREET, SUITE 300 & 400		
DAARIO	COMMUNITY HEALTH	DURHAN	I, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 237	Mental Health Servi or The Center for S (CSAT) Regulations certified by a private agency, that has be of the United State Human Services an all SAMHSA Opioid Detoxification Treat regulations in 42 CF incorporated by refe amendments and e available from the C 5600 Fishers Lane, no cost. (c) Compliance Wi facility shall be curre Federal Drug Enfor shall be in compliar Administration regular incorporated by refe amendments and e available from the C Shall be in compliar Administration regular incorporated by refe amendments and e available from the C Printing Office, Was published rate.	ge 3 h The Substance Abuse and ices Administration (SAMHSA) ubstance Abuse Treatment s. Each facility shall be e non-profit entity or a State en approved by the SAMHSA Department of Health and nd shall be in compliance with Drugs in Maintenance and ment of Opioid Addiction FR Part 8, which are erence to include subsequent ditions. These regulations are CSAT, SAMHSA, Rockwall II, Rockville, Maryland 20857 at th DEA Regulations. Each ently registered with the cement Administration and nee with all Drug Enforcement lations pertaining to opioid s codified in 21 C.F.R., Food D0 to end, which are erence to include subsequent ditions. These regulations are Jnited States Government shington, D.C. 20402 at the th State Authority Regulations.				
	Carolina State Auth DMH/DD/SAS, which the Secretary of He exercise the responstate for governing an opioid drug, inclu- monitoring compliant	e approved by the North ority for Opioid Treatment, ch is the person designated by alth and Human Services to asibility and authority within the the treatment of addiction with uding program approval, for nce with the regulations aff, and operations, and for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPL	
			A. DOILDING	·	R	•
		MHL032-412	B. WING			1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
BAART (	COMMUNITY HEALTH		RTH MANGUN M, NC 27701	/ STREET, SUITE 300 & 400		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLET DATE
V 237	Continued From pa	age 4	V 237			
	102-321. The refer	nce with Section 1923 of P.L. renced material may be Substance Abuse Services D/SAS.				
	Based on record re facility managemen with regulations in a an annual physical Addiction affecting	et as evidenced by: eviews and interviews, the nt failed to assure compliance 42 CFR Part 8 which require during treatment for Opioid three of eighteen audited #3 and #4). The findings are:		BAART Programs Durham's leadership is currently in the process of streamlining the annual physical proce within the EMR and the addition of hiri in order to ensure there is a consisten necessary documentation that needs	ess ing a NP/PA nt flow of	11/20/2:
	revealed: - Admission date of - Diagnosis of Opio - Documentation of examination by a p 11/9/20. - There was no doc			completed all in one place. This will ir timely completion of the annual physic examination. This modification within t and procedure will assist in ensuring a annual documentation is missing durir evaulation process. This will also ens required annual training, documentati assessments are also completed. All r will receive training on the revised wor later than October 31st, 2022. In addit	cal he process that no ng the annual ure that all on, and nedical staff kflow no	
	<ul> <li>b. Review on 9/21/22 of client #3's record revealed:</li> <li>Admission date of 9/20/18.</li> <li>Diagnosis of Opioid Use Disorder.</li> <li>Documentation of the client's last physical examination by a physician was completed on 9/20/18.</li> <li>There was no documentation an annual physical was completed by a physician within the last y</li> </ul>			Clinical Director and Treatment Center will complete at least 10 chart reviews month to ensure all of the necessary of and documentation are present. The of the annual physical workflow is exp completed no later than October 31st,	r Director each omponents finalization ected to be	
	c. Review on 9/21/2 revealed: ealth Service Regulation	22 of client #4's record				

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
BAART	COMMUNITY HEALTH		ORTH MANGUM AM, NC 27701	STREET, SUITE 300 & 400	)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 237	<ul> <li>Admission date of</li> <li>Diagnosis of Opio</li> <li>Documentation of</li> <li>examination by a pl</li> <li>8/21/19.</li> <li>There was no doc</li> <li>was completed by a</li> <li>Interview on 9/21/2.</li> <li>revealed:</li> <li>She thought client</li> <li>annual physical cor</li> <li>She thought clients</li> <li>scheduled to have a</li> <li>completed as well.</li> <li>She confirmed the</li> <li>was not completed</li> <li>#3 and #4.</li> <li>Interview on 9/21/2.</li> <li>Director confirmed:</li> <li>The annual physical</li> </ul>	<ul> <li><sup>2</sup> 8/13/07.</li> <li><sup>3</sup> 8/13/07.</li> <li><sup>4</sup> id Use Disorder.</li> <li><sup>5</sup> the client's last physical hysician was completed on sumentation an annual physic a physician within the last year 2 with the Lead Nurse</li> <li>#1 was scheduled to have h npleted October 2022.</li> <li>#3 and #4 were also their annual physical examination by the physician for clients #</li> <li>2 with the Treatment Center</li> </ul>	ar. is n ¢1,			
V 238	10A NCAC 27G .36 TREATMENT. OPE (e) The State Auth approval on the foll (1) compliand law and regulations (2) compliand standards of practic (3) program s service delivery; an (4) impact on	ority shall base program owing criteria: ce with all state and federal ; ce with all applicable ce; structure for successful	V 238			

Division of Health Service Regulation STATE FORM

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If continuation sheet 6 of 15

Division	of Health Service Re	egulation				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL032-412	B. WING		F 09/2	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAART	COMMUNITY HEALTH		TH MANGUN , NC 27701	I STREET, SUITE 300 & 400		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 238	requests unsupervi methadone or othe treatment of opioid specified requirement treatment. The clie requirements for co and must demonstr the specified time p any level increase. year of continuous attend a minimum of month. After the fir years of continuous attend a minimum of month. After the fir years of continuous attend a minimum of month. (1) Levels of following conditions (A) Level 1. If continuous treatme limited to a single of shall ingest all othe the clinic; (B) Level 2. continuous program granted for a maxin and shall ingest all at the clinic each w (C) Level 3. treatment and a mi continuous program client may be grant take-home doses a under supervision a (D) Level 4. A	piblity. Any client in intenance treatment who sed or take-home use of r medications approved for addiction must meet the ents for time in continuous ent must also meet all the portinuous program compliance rate such compliance during periods immediately preceding In addition, during the first treatment a patient must of two counseling sessions per rst year and in all subsequent as treatment a patient must of one counseling session per Eligibility are subject to the s: During the first 90 days of ent, the take-home supply is lose each week and the client r doses under supervision at After a minimum of 90 days of n compliance, a client may be num of three take-home doses other doses under supervision				

STATE DUENOY F CORRECTION       (x) M PROVIDER/SUPPLIENCUE       (x) MULTIPLE CONSTRUCTION       (x) MULTIPLE CATION NUMBER:       (x) MULTIPLE CATION NUMBER: <td< th=""><th>Division</th><th>of Health Service Re</th><th>egulation</th><th></th><th></th><th></th><th></th></td<>	Division	of Health Service Re	egulation				
MHL032-412         MMMC         OP/21/2022           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE         B00 NORTH MANCUM STREET, SUITE 300 & 400 DURHAM, NC 27701           MAIL OF PROVIDER OR SUPPLIER         SUMMONTH MEALTHCARE         B00 NORTH MANCUM STREET, SUITE 300 & 400 DURHAM, NC 27701         Control 400 CONRECTION HE STREET, SUITE 300 RA OF CORRECTION HE CASES AND FEEDENCE TO THE APPROPRIATE (EACH COMPECTIVE WEST BE PRECEDED BY FULL FROM COMPECTIVE OR USE DENTIFYING INFORMATION)         PACE         CONSERTERCED TO THE APPROPRIATE (EACH COMPECTIVE AND THE PROVIDER'S PLAN OF CORRECTION HE CASES AND THE ADDRESS (FEACH FOR YOR USE DENTIFYING INFORMATION)         V238         Continued From page 7         V238           V238         Continued From page 7         V238         V238         Continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F)         V238         Level 6. After two years of continuous treatment and a minimum of ne year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and (G)         Level 7. After four years of continuous treatment and a minimum of two treats of continuous treatment and a minimum of our gas role continuous treatment of Take-Home Eligibility: reduced or suspended for exidence of recent drug abuse. A client who tests positive on three drug screens within the same 90-day period shall have at take-home eligibility suspended; and (C)         Content dake-home eligibility; (B)         A client two bests posidive	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
BOO NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701           PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY DEPRICENCY)         COMPLETE DEFRIENCY           V 238         Continued From page 7         V 238         V 238         V <t< td=""><td></td><td></td><td>MHL032-412</td><td>B. WING</td><td></td><td></td><td></td></t<>			MHL032-412	B. WING			
BOO NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701           PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL PRETEX         PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY DEPRICENCY)         COMPLETE DEFRIENCY           V 238         Continued From page 7         V 238         V 238         V <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>						-	
DURHAM, NC 27701           VALUE TWO         SUMMARY STATEMENT OF DETICENCIES         DURHAM, NC 27701           V238         SUMMARY STATEMENT OF DETICENCIES         0		FROMBER OR SOFFEIER					
race Tage       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTIORY OF LSC IDENTIFYING INFORMATION)       PREFX Tage       (EACH CORRECTIVE ACTION SHOULD BE CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         V238       Continued From page 7       V 238         V238       Lave-home doses and shall ingest all other doses under supervision at the clinic each week; (E)       V 238         (E)       Level 5. After 304 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F)       V 238         (G)       Level 7. After four years of continuous treatment and a minimum of 10 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and       (G)         (G)       Level 7. After four years of continuous treatment and a minimum of so take-home doses and shall ingest at least one dose under supervision at the clinic every month.         (Z)       Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility; (A)       A client two tests positive on two drug socreens within a 90-day period shall have an immediate reduction of eligibility shall be determined by each Outpatient Opioid Treatment Program.         (B)       A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility;         (A)       A client who tests positive on three drug screens thin the farke-home Eligibility;         (A)       A client tho tatex-home Eligibilit	BAART	COMMUNITY HEALTH	IGARE				
<ul> <li>take-home docse and shall ingest all other doses under supervision at the clinic each week;</li> <li>(E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week;</li> <li>(F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic each week;</li> <li>(F) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 31 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and</li> <li>(G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month.</li> <li>(2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility:</li> <li>(A) A client's take-home Eligibility:</li> <li>(B) A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility source level of eligibility;</li> <li>(B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility;</li> <li>(C) The reinstatement of take-home Eligibility;</li> <li>(A) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility for the same 90-day period shall have all take-home eligibility;</li> <li>(B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility;</li> <li>(A) A client who tests positive on three drug screens wit</li></ul>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
<ul> <li>(F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and</li> <li>(G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month.</li> <li>(2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility:</li> <li>(A) A client's take-home eligibility:</li> <li>(B) A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility by one level of eligibility;</li> <li>(B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility supended; and</li> <li>(C) The reinstatement of take-home Eligibility;</li> <li>(B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility by one level of eligibility;</li> <li>(B) A client the first two years of continuous and take-home eligibility supended; and</li> <li>(C) The reinstatement of take-home Eligibility;</li> <li>(A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of</li> </ul>		under supervision a (E) Level 5. treatment and a mi continuous program granted for a maxim and shall ingest at	at the clinic each week; After 364 days of continuous nimum of 180 days of n compliance, a client may be num of six take-home doses least one dose under				
exceptional circumstances such as illness,		supervision at the of (F) Level 6. If treatment and a mill continuous program client may be grant take-home doses a dose under supervisidays; and (G) Level 7. treatment and a mill continuous program granted for a maxim and shall ingest at 1 supervision at the of (2) Criteria for Reinstatement of T (A) A client's to or suspended for end A client who tests point within a 90-day per- reduction of eligibilit (B) A client we screens within the sall take-home eligibilit (C) The reins- eligibility shall be de Opioid Treatment F (3) Exception (A) A client in continuous treatment the applicable man	clinic each week; After two years of continuous nimum of one year of a compliance at level 5, a ed for a maximum of 13 and shall ingest at least one sion at the clinic every 14 After four years of continuous nimum of three years of a compliance, a client may be num of 30 take-home doses east one dose under clinic every month. or Reducing, Losing and ake-Home Eligibility: take-home eligibility is reduced vidence of recent drug abuse. to sitive on two drug screens iod shall have an immediate ty by one level of eligibility; tho tests positive on three drug same 90-day period shall have bility suspended; and statement of take-home etermined by each Outpatient Program. to Take-Home Eligibility: the first two years of nt who is unable to conform to datory schedule because of				
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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V 238	Continued From pa	age 8	V 238			
	personal or family may be permitted a by the State author found to be respon Except in instance verifiable physical of 13 take-home d period during the fit treatment. (B) A client w applicable mandat verifiable physical additional take-hor authority. Clients w take-home eligibilit disability may be g 30-day supply of ta make monthly clini (4) Take-Home disability may be g 30-day supply of ta make monthly clini (4) Take-Home disability may be g addiction shall be a physician on an indi- to the following: (A) An addition methadone or othe treatment of opioid to each eligible client restriction shall not receiving take-home above. (g) Withdrawal Fro Opioid Treatment.	crisis, travel or other hardsh a temporarily reduced scheo rity, provided she or he is als asible in handling opioid drug s involving a client with a disability, there is a maximu oses allowable in any two-w irst two years of continuous who is unable to conform to ory schedule because of a disability may be permitted ne eligibility by the State who are granted additional cy due to a verifiable physical ranted up to a maximum ake-home medication and sh c visits. me Dosages For Holidays: es of methadone or other ved for the treatment of opio authorized by the facility dividual client basis accordin onal one-day supply of er medications approved for addiction may be dispense ent (regardless of time in	ip lule so js. meek the l hall oid g the d			

	of Health Service Re					I		
	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED	
		MHL03	2-412	B. WING		R 09/21/2		
AME OF F	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BAART (	COMMUNITY HEALTH	ICARE		TH MANGUM M, NC 27701	STREET, SUITE 300 & 400			
(X4) ID	SUMMARY STA	TEMENT OF DEI		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PREC	EDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE	
V 238	Continued From pa	ge 9		V 238				
	approved for use in	opioid treatr	nent shall be					
	discussed with eacl	h client at the	e initiation of					
	treatment and annu							
	(h) Random Testin and other drugs sha							
	active opioid treatm							
	one random drug te	est each mon	th of continuous					
	treatment. Addition							
	three-month period treatment episode,							
	will be observed by							
	to include at least the							
	methadone, cocain							
	amphetamines, TH alcohol. Alcohol tes							
	by either urinalysis,							
	alternate scientifica	lly valid meth	nod.					
	(i) Client Discharge							
	be discharged from dependent upon me							
	approved for use in							
	client is provided th							
	the drug.		-					
	(j) Dual Enrollment							
	outpatient opioid ac which dispense Me		nent lacinties					
	Levo-Alpha-Acetyl-		AM) or any other					
	pharmacological ag			k				
	Drug Administration							
	addiction subseque required to participa							
	Registry or ensure							
	enrolled by means	of direct cont	act or a list					
	exchange with all o							
	within at least a 75- program. Program							
	participate in a com							
	Management and V							
	System as establish						1	

	Division	of Health Service Re	egulation				
MHL032-412         B. WING         O9/21/2022           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701           (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         V 238         Continued From page 10         V 238         Continued From page 10         V 238         V 238         V 238         Continued From page 10         V 238         V 238         V 10         State Authority for Opioid Treatment. (K) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for bottle checks, bottle returns or solid dosage form call-in's; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction; (5) client attendance minimums; and (6) procedures to ensure that clients         II = 0000000000000000000000000000000000	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			
BAART COMMUNITY HEALTHCARE       BOU NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMMEND COMMEND DATE         V 238       Continued From page 10       V 238       V 238       Enclose the second control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: <ol> <li>dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges;</li> <li>call-in's for drug testing;</li> <li>dual ensuits that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction;</li> <li>client attendance minimums; and (6) procedures to ensure that clients</li> </ol>			MHL032-412	B. WING			
BARK COMMUNITY HEALTHCARE     DURHAM, NC 27701       (x4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     Communication Communication Date       V 238     Continued From page 10     V 238       State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for drug testing; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction; (5) client attendance minimums; and (6) procedures to ensure that clients	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       cowince DATE         V 238       Continued From page 10       V 238       V 238       V 238       V 238         State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements:       V 10       dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges;       (2)       call-in's for drug testing;         (4)       drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction;       (5)       client attendance minimums; and (6)       (6)	BAART	COMMUNITY HEALTH			I STREET, SUITE 300 & 400		
State Authority for Opioid Treatment.         (k) Diversion Control Plan. Outpatient Addiction         Opioid Treatment Programs in North Carolina are         required to establish and maintain a diversion         control plan as part of program operations and         shall document the plan in their policies and         procedures. A diversion control plan shall include         the following elements:         (1)       dual enrollment prevention measures         that consist of client consents, and either         program contacts, participation in the central         registry or list exchanges;         (2)       call-in's for bottle checks, bottle returns         or solid dosage form call-in's;         (3)       call-in's for drug testing;         (4)       drug testing results that include a         review of the levels of methadone or other         medications approved for the treatment of opioid         addiction;         (5)       client attendance minimums; and         (6)       procedures to ensure that clients	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
<ul> <li>(k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: <ul> <li>(1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges;</li> <li>(2) call-in's for bottle checks, bottle returns or solid dosage form call-in's;</li> <li>(3) call-in's for drug testing;</li> <li>(4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction;</li> <li>(5) client attendance minimums; and</li> <li>(6) procedures to ensure that clients</li> </ul> </li> </ul>	V 238	Continued From pa	age 10	V 238			
This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure after the first year and in all subsequent years of continuous treatment a client attended at least one counseling session per month affecting two of eighteen current audited clients (#4 and #6) and failed to ensure counseling sessions were completed after a		<ul> <li>(k) Diversion Conta Opioid Treatment F required to establis control plan as part shall document the procedures. A dive the following eleme (1) dual enro that consist of clien program contacts, registry or list exch. (2) call-in's fo or solid dosage form (3) call-in's fo (4) drug testi review of the levels medications approvaddiction; (5) client atter (6) procedure properly ingest med</li> <li>This Rule is not me Based on record re facility failed to ens all subsequent year client attended at le per month affecting audited clients (#4</li> </ul>	rol Plan. Outpatient Addiction Programs in North Carolina are th and maintain a diversion t of program operations and plan in their policies and ersion control plan shall include ents: Illment prevention measures at consents, and either participation in the central anges; or bottle checks, bottle returns m call-in's; or drug testing; ng results that include a s of methadone or other ved for the treatment of opioid endance minimums; and es to ensure that clients dication. et as evidenced by: eviews and interviews, the ure after the first year and in rs of continuous treatment a east one counseling session g two of eighteen current and #6) and failed to ensure		in the process of recruiting and hiring sta ensure we met the counselor: patient ratio. This assist counselors in being able to met with each after their first year and in all subsequent	aff to is will h patient t years of	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		MHL032-412	В.	WING		F 09/2	1/2022	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, S	STATE, ZIP CODE			
BAART	COMMUNITY HEALTH	ICARE	800 NORTH I DURHAM, NO		STREET, SUITE 300 & 400			
(X4) ID		TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA		PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
V 238	Continued From pa	ge 11	V	/ 238	A training will be held on or bef		11/20/22	
	eighteen current au #6) The findings ar	dited clients (#2, #3, re:	#5 and		clinical staff to address state rul regarding required counseling regarding completing a counsel	session and the rule		
	The following is evidence the facility staff failed to ensure clients attended at least one counseling session per month.				positive urine drug screen.			
	revealed:	-Admission date of 8/13/07.						
	-Diagnosis of Opioi -Staff #1 was her c							
	revealed: -Admission date of -Diagnosis of Opioi -Staff #6 was his cu							
		2 with staff #1 reveal d with the facility since						
	-Client #4 was adde -She had not met w sessions.	ounselor for client #4. added to her caseload last month. et with client #4 for any counseling facility staff failed to ensure at least one counseling session						
	Staff #6 was not av	ailable for interview.						
	Director confirmed:	2 with the Treatment to ensure clients atte						

STATE FORM

Division of Health Service Regulation         STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
MHL032-412		B. WING			R 09/21/2022		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
BAART (	COMMUNITY HEALTH	CARE		STREET, SUITE 300 & 400			
		DURHAN	I, NC 27701	PROVIDER'S PLAN OF		()(7)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 238	Continued From pa	ge 12	V 238				
	The following is evidence the facility staff failed to ensure counseling sessions were completed after a positive urine drug screen.						
	<ul> <li>a. Review on 9/21/22 of client #2's record revealed:</li> <li>-Admission date of 2/14/17.</li> <li>-Diagnoses of Opioid Use Disorder, Major Depressive Disorder and Hepatitis C.</li> <li>-Staff #5 was her current Counselor.</li> <li>-Urinary Drug Screens (UDS) were completed on 8/15/22, 7/7/22 and 6/28/22. Client #2 tested positive for Cannabis.</li> <li>-There was no documentation of counseling sessions completed by client #2's Counselor to address the positive UDS results.</li> <li>b. Review on 9/21/22 of client #3's record revealed:</li> <li>-Admission date of 9/20/18.</li> <li>-Diagnosis of Opioid Use Disorder.</li> </ul>						
	-Staff #1 was his cu -UDS were complet 6/22/22. Client #3 to -There was no docu	Irrent Counselor. ted on 8/19/22, 7/15/22 and ested positive for Cannabis. Imentation of counseling by client #3's Counselor to					
	revealed: -Admission date of -Diagnosis of Opioi -Staff #5 was his cu -UDS was complete positive for Cocaine -There was no docu	d Use Disorder. urrent Counselor. ed on 9/2/22. Client #5 tested e and Fentanyl. umentation of counseling d by client #5's Counselor to					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 09/21/2022	
		MHL032-412				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BAART	COMMUNITY HEALTH	ICARE	RTH MANGUM M, NC 27701	STREET, SUITE 300 & 400	)	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 238	Continued From page 13		V 238			
	revealed: -UDS were completed 6/1/22 . Client #6 to Fentanyl. -There was no document sessions completed address the positive Interview on 9/21/2. -She was the Coun -She had her first of #3 in August 2022. -She just had a cour (September 21, 2022) -She knew client #3 discuss client #3's of their counseling ses -She confirmed fac	2 with staff #1 revealed: selor for client #3. ounseling session with client useling with client #3 on today 22). 3 used Cannabis. She didn't use of the Cannabis during ssions. ility staff failed to ensure s were completed after a				
	-She was the Coun -She knew client #2 several times. -Client #2 refused t because she said it -She talked with clie using Cannabis dur -She didn't docume about her use of Ca sessions. -Client #5 was also -She knew client #5 substances at the b -She wasn't sure wi #5 after that positiv -She confirmed fac	2 tested positive for Cannabis to stop using Cannabis t helped with her anxiety. ent #2 several times about not ring their counseling sessions. ent she talked with client #2 annabis during their counseling on her caseload. 5 tested positive for illicit beginning of September 2022. hy she had not met with client	g			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-412		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILDING:			
		B. WING			R 09/21/2022	
ME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AART C			RTH MANGUM	STREET, SUITE 300 & 400		
X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
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V 238	Continued From page 14		V 238			
	positive urine drug screen					
	Staff #6 was not available for interview.					
	Interview on 9/21/22 with the Treatment Center Director confirmed:					
	-Facility staff failed to ensure counseling sessions were completed after a positive urine drug		5			
	screen.					