Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			756.2516.		D C
		MHL032-233	B. WING	 	R-C 10/12/2023
NAME OF D	ROVIDER OR SUPPLIER	QTPEET AF	DDRESS, CITY, STATE	ZIR CODE	-
INAME OF T	NOVIDEN ON 3011 LIEN		MAR STREET	-, 211 GODE	
DURHAM	TREATMENT CENTER		I, NC 27705		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000		
	A complaint and follow on October 12, 2023. unsubstantiated (Intal Deficiencies were cite	ke #NC00207075).			
		d for the following service 27G .3600 Outpatient			
	•	rent census of 298. The ted of audits of 14 current			
V 235	27G .3603 (A-C) Outp	ot. Opiod Tx Staff	V 235		
	V 235 27G .3603 (A-C) Outpt. Opiod Tx Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome;				
	hiring area, then it may person, provided that certification requirement months from the date (b) Each facility shall member on duty train (1) drug abuse (2) symptoms of the following: (c) Each direct care so continuing education the following: (1) nature of add (2) the withdraw (3) group and face	ay employ an uncertified this employee meets the ents within a maximum of 26 of employment. have at least one staff ed in the following areas: withdrawal symptoms; and of secondary complications staff member shall receive to include understanding of			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74101 1244	or connection	ISERTIN IS A TOTAL TOMBER.	A. BUILDING: _		
		MHL032-233	B. WING		R-C 10/12/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
DURHAM	TREATMENT CENTER		AR STREET NC 27705		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 235	Continued From page	: 1	V 235		
	sexually transmitted of	diseases and TB.			
	This Rule is not met				
		ew and interviews, the e a minimum of one certified			
	drug abuse counselor	r or certified substance ach 50 clients. The findings			
	Review on 10/12/23 of facility records revealed: -The facility had a census of 298 clientsThe facility had four full time substance abuse				
	counselorsCounselor #1 had a	caseload of 72 clients.			
	-Counselor #2 had a	caseload of 56 clients.			
		caseload of 85 clients. caseload of 72 clients.			
	Interview on 10/12/23 revealed:	with the Program Director			
	-He started in the pos -They had 2 counsels hired.	ition May 2023. ors in the process of being			
	-He confirmed the fac	ility failed to ensure there unselor to every 50 or less			
	This deficiency consti and must be corrected	tutes a re-cited deficiency d within 30 days.			
V 238	27G .3604 (E-K) Outp	ot. Opiod - Operations	V 238		

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 2 of 9

Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	·
		MHL032-233	B. WING		1	2/2023
			1		10/12	72020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DURHAM	TREATMENT CENTER	1913 LAM	AR STREET			
	THE TIMENT SERVER	DURHAM,	NC 27705			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	REGOLATOR OR		IAG	DEFICIENCY)		
V 238	Continued From page	2	V 238			
		4 OUTPATIENT OPIOD				
	TREATMENT. OPER					
		ity shall base program				
	approval on the follow	•				
		with all state and federal				
	law and regulations;	with all and back to				
	(2) compliance standards of practice;	with all applicable				
		ucture for successful				
	service delivery; and	ucture for successful				
	_	ne delivery of opioid				
		the applicable population.				
	(f) Take-Home Eligib					
		tenance treatment who				
	•	d or take-home use of				
	methadone or other n	nedications approved for				
	treatment of opioid ac	ddiction must meet the				
		ts for time in continuous				
		must also meet all the				
	=	inuous program compliance				
		e such compliance during				
		iods immediately preceding				
	_	n addition, during the first				
		eatment a patient must two counseling sessions per				
		year and in all subsequent				
		reatment a patient must				
		one counseling session per				
	month.	o ooog ooo po.				
		igibility are subject to the				
	following conditions:					
		ring the first 90 days of				
		, the take-home supply is				
		se each week and the client				
		doses under supervision at				
	the clinic;					
		ter a minimum of 90 days of				
		compliance, a client may be				
	granted for a maximu	m of three take-home doses				

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 3 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING			_
		MHL032-233	B. WING		R- 10/1	C 2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DUDUAM	TREATMENT CENTER	1913 LAN	IAR STREET			
DURHAM	TREATMENT CENTER	DURHAM	, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 238	Continued From page	3	V 238			
	and shall ingest all of at the clinic each wee (C) Level 3. Af treatment and a minir continuous program of client may be granted take-home doses and under supervision at (D) Level 4. Aft treatment and a minir continuous program of client may be granted take-home doses and under supervision at (E) Level 5. Af treatment and a minir continuous program of granted for a maximuland shall ingest at leasupervision at the clir (F) Level 6. Af treatment and a minir continuous program of client may be granted take-home doses and dose under supervision days; and (G) Level 7. Aftereatment and a minir continuous program of client may be granted take-home doses and dose under supervision days; and (G) Level 7. Aftereatment and a minir continuous program of granted for a maximuland shall ingest at leasupervision at the clir (2) Criteria for I Reinstatement of Tak (A) A client's take or suspended for evice A client who tests possible for the client who tests po	her doses under supervision k; ter 180 days of continuous num of 90 days of compliance at level 2, a for a maximum of four I shall ingest all other doses the clinic each week; er 270 days of continuous num of 90 days of compliance at level 3, a for a maximum of five I shall ingest all other doses the clinic each week; ter 364 days of continuous num of 180 days of compliance, a client may be m of six take-home doses ast one dose under nic each week; ter two years of continuous num of one year of compliance at level 5, a for a maximum of 13 I shall ingest at least one on at the clinic every 14 Ter four years of continuous num of three years of compliance, a client may be m of 30 take-home doses ast one dose under nic every month. Reducing, Losing and				

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 4 of 9

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL032-233	B. WING		R- 10/1	C 2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
DURHAM TREATMENT CENTER			AR STREET NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 238	(B) A client who screens within the sar all take-home eligibility (C) The reinsta eligibility shall be determined opioid Treatment Pro (3) Exceptions (A) A client in the continuous treatment the applicable manda exceptional circumstate personal or family crismany be permitted a test by the State authority found to be responsibe Except in instances in verifiable physical distof 13 take-home dose period during the first treatment. (B) A client who applicable mandatory verifiable physical distoral take-home authority. Clients who take-home eligibility of disability may be grandod supply of take make monthly clinic verifiable physical disability may be grandod supply of take make monthly clinic verifiable physical disability may be grandod supply of take make monthly clinic verifiable physical disability may be grandod supply of take make monthly clinic verifiable physical disability may be grandod supply of take make monthly clinic verifiable physical on an indivito the following: (A) An additional methadone or other in the same supplied to the following: (A) An additional methadone or other in the same supplied to the following: (A) An additional methadone or other in the same supplied to the following: (B) A client who are supplied to the following: (B) A client who are supplied to the following: (C) The reinstance of the reinstance of the same supplied to the same s	by one level of eligibility; of tests positive on three drug me 90-day period shall have by suspended; and tement of take-home ermined by each Outpatient gram. Ito Take-Home Eligibility: e first two years of who is unable to conform to tory schedule because of unces such as illness, sis, travel or other hardship emporarily reduced schedule, provided she or he is also ble in handling opioid drugs. Involving a client with a ability, there is a maximum as allowable in any two-week two years of continuous It is unable to conform to the schedule because of a ability may be permitted eligibility by the State of are granted additional lue to a verifiable physical atted up to a maximum thome medication and shall isits. Dosages For Holidays: of methadone or other diffor the treatment of opioid	V 238			

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 5 of 9

Division of Health Service Regulation

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				R-C
	MHL032-233	B. WING		10/12/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	1913 LAM	AR STREET		
DURHAM TREATMENT CENTER	DURHAM,	NC 27705		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 238 Continued From page	5	V 238		
to each eligible client (treatment) for each sta (B) No more that methadone or other methadone. (g) Withdrawal From I Opioid Treatment. The withdrawal from methadone or other methadone or other drugs shall be active opioid treatment and annually (h) Random Testing, and other drugs shall be active opioid treatment one random drug test treatment. Additionally three-month period of treatment episode, at I will be observed by proto include at least the methadone, cocaine, be amphetamines, THC, alcohol. Alcohol testing by either urinalysis, broalternate scientifically (i) Client Discharge Rebe discharged from the dependent upon methadone, cocine, is approved for use in opicient is provided the othe drug. (j) Dual Enrollment Provided Incomplete Inco	regardless of time in ate holiday. In a three-day supply of edications approved for the diction may be dispensed ecause of holidays. This ply to clients who are nedications at Level 4 or Medications For Use In erisks and benefits of adone or other medications soloid treatment shall be lient at the initiation of y thereafter. Random testing for alcohol be conducted on each to client with a minimum of each month of continuous each month of continuous east one random drug test or aclient's continuous following: opioids, parbiturates, benzodiazepines and agresults can be gathered eathalyzer or other valid method. Estrictions. No client shall be facility while physically adone or other medications shoid treatment unless the apportunity to detoxify from eevention. All licensed ction treatment facilities	V 250		

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 6 of 9

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-	С
		MHL032-233	B. WING			2/2023
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		1913 LAMA	AR STREET			
DURHAM IF	REATMENT CENTER	DURHAM,	NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 238	Continued From page	6	V 238			
F C C C C C C C C C C C C C C C C C C C	charmacological ager Drug Administration for addiction subsequent required to participate Registry or ensure that enrolled by means of exchange with all opic within at least a 75-mi program. Programs a participate in a computation of the exchange with all opic within at least a 75-mi program. Programs a participate in a computation of the exchangement and Wall System as established State Authority for Op (k) Diversion Control Opioid Treatment Progrequired to establish a control plan as part of shall document the plantation of the following elements (1) dual enrollm that consist of client corogram contacts, participate in a control dosage form of the control dosage form of the exchange (2) call-in's for the exchange (3) call-in's for the except of the levels of medications approved addiction; (5) client attended.	at approved by the Food and or the treatment of opioid to November 1, 1998, are in a computerized Central at clients are not dually direct contact or a list oid treatment programs ille radius of the admitting are also required to atterized Capacity iting List Management do by the North Carolina ioid Treatment. Plan. Outpatient Addiction grams in North Carolina are and maintain a diversion of program operations and an in their policies and ion control plan shall include in the provention measures consents, and either tricipation in the central ges; cottle checks, bottle returns call-in's; drug testing; results that include a finethadone or other a for the treatment of opioid stance minimums; and to ensure that clients				

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 7 of 9

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		MHL032-233	B. WING		10/12/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
DURHAM 1	TREATMENT CENTER		MAR STREET			
	OUR MAN DV OT		I, NC 27705	DD0//DDD0 D/ AV 05 00DD507/0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 238	Continued From page	e 7	V 238			
	facility failed to ensure completed after a post (UDS) affecting three clients (#4, #6 and #1 Review on 10/11/23 or revealed: -Admission date of 7/-Diagnosis of Opioid U-There were only 2 coadmission to the progrevealed: -Admission date of 6/4-Diagnosis of Opioid U-Diagnosis of Opioid	ew and interviews, the e counseling sessions were sitive Urine Drug Screen of fourteen audited current 4). The findings are: of Client #4's record 7/23. Use Disorder. ounseling sessions since gram 10/3/23 and 10/10/23. of Client #6's record 4/18. Use Disorder. 2 counseling sessions for				
	Review on 10/11/23 of Client #14's record revealed:					
	-Admission date of 6/2					
	-Diagnosis of Opioid I-Client tested positive	e each month for Urine Drug				
	Screens.	-				
	-Client received only of 9/29/23 since admissi	one counseling session on ion to the program.				
	and Regional Clinicial -Regional clinical supcounselors.	with the Program Director I Supervisor revealed: ervisor supervises the ens were 30-minute sessions				

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 8 of 9

Division of Health Service Regulation

	STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1913 LAMAR STREET DURHAM, NC 27705 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 238 Continued From page 8 -There was a productivity report for each counselor.			MUI 022 222	B. WING			000
DURHAM, NC 27705 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 238 Continued From page 8 -There was a productivity report for each counselor.				-		10/12/20	023
DURHAM, NC 27705 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 238 Continued From page 8 -There was a productivity report for each counselor.	NAME OF P	ROVIDER OR SUPPLIER			TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 238 Continued From page 8 -There was a productivity report for each counselor.	DURHAM TREATMENT CENTER DURHAM						
-There was a productivity report for each counselor.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CO	(X5) OMPLETE DATE
counselor at least once a monthSent out patient list to each counselor without case notes at least once a weekCounselors had access to running the report and recommended that they reviewed weeklyClients admitted after one year required once a month counseling sessionClients admitted less than one year required twice a month counseling sessionClients with repeated positive UDS would require individual and group sessionsThey would continue to run the reports for compliance. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 238	-There was a product counselorThey would run a recounselor at least one-Sent out patient list to case notes at least or Counselors had accerecommended that the Clients admitted after month counseling sestimice a month counselors with repeated individual and group set They would continue compliance.	quirement report on each ce a month. o each counselor without nee a week. ess to running the report and ey reviewed weekly. r one year required once a ssion. than one year required eling session. d positive UDS would require sessions. to run the reports for	V 238			

Division of Health Service Regulation

STATE FORM 6899 HCN011 If continuation sheet 9 of 9