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	MHL068-165	A. BUILDING: _____ B. WING _____	06/06/2024

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HILLSBOROUGH COMPREHENSIVE TREATME	129 MAYO STREET HILLSBOROUGH, NC 27278

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V 000	INITIAL COMMENTS An annual survey was completed on June 6, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. This facility has a current census of 137. The survey sample consisted of audits of 12 current clients and 1 deceased client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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.	V 112		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to schedule a review of a plan at least annually affecting four of twelve audited current clients (#1, #2, #3 and #9). The findings are:

Review on 6/5/24 of client #1's record revealed:
-Admission date of 1/24/23.
-Diagnosis of Opioid Use Disorder.
-Person Centered Plan (PCP) dated 1/24/23.
-There was no documentation of a current plan.

Reviews on 6/5/24 and 6/6/24 of client #2's record revealed:
-Admission date of 3/21/23.
-Diagnosis of Opioid Use Disorder.
-PCP dated 3/21/23.
-There was no documentation of a current plan.

Review on 6/6/24 of client #3's record revealed:
-Admission date of 10/3/23.
-Diagnosis of Opioid Use Disorder.
-There was no documentation of a plan.

Review on 6/6/24 of client #9's record revealed:
-Admission date of 9/5/19.
-Diagnosis of Opioid Use Disorder.
-PCP dated 3/3/23.
-There was no documentation of a current plan.

Interviews on 6/5/24 and 6/6/24 with the Regional

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V 112	Continued From page 2 Clinical Supervisor revealed: -The PCP for client #2 was "put into the old system." -Counselor #1 said the PCP for client #2 was possibly misplaced. -She (the Regional Clinical Supervisor) was the Counselor for client #3. -She didn't realize client #3 had no PCP. -She had no explanation for the reason clients #1 and #9 had no current PCP. -She confirmed the facility failed to schedule a review of a plan at least annually for clients #1, #2, #3 and #9.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;	V 113		

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V 113	Continued From page 3 (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain required documentation in the client records affecting one of twelve audited current clients (#1) and one of one audited deceased client (DC #13). The findings are: Review on 6/5/24 of client #1's record revealed: -Admission date of 1/24/23. -Diagnosis of Opioid Use Disorder. -A signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician. Review on 6/6/24 of DC #13's record revealed:	V 113		

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V 113	Continued From page 4 -Admission date of 1/23/24. -Diagnosis of Opioid Use Disorder. -He died on 4//4/24. -A signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician. Interviews on 6/5/24 and 6/6/24 with the Regional Clinical Supervisor revealed: -They had been checking the client records to see if there were any missing documentation. -She wasn't sure why there was no permission to seek emergency care consent in the record for client #1 and DC #13. -She confirmed the facility failed to maintain completed records for client #1 and DC #13.	V 113		
V 238	27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program approval on the following criteria: (1) compliance with all state and federal law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance	V 238		

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and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month.

(1) Levels of Eligibility are subject to the following conditions:

(A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic;

(B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week;

(C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week;

(D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five take-home doses and shall ingest all other doses under supervision at the clinic each week;

(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;

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V 238	Continued From page 6 (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 (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. (2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility: (A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. 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; (B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and (C) The reinstatement of take-home eligibility shall be determined by each Outpatient Opioid Treatment Program. (3) Exceptions to Take-Home Eligibility: (A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous	V 238		

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treatment.
(B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall make monthly clinic visits.
(4) Take-Home Dosages For Holidays: Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following:
(A) An additional one-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday.
(B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above.
(g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter.
(h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each

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V 238	Continued From page 8 three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method. (i) Client Discharge Restrictions. No client shall be discharged from the facility while physically dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug. (j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina 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 238		

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V 238	Continued From page 9 (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 properly ingest medication. 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 six of twelve audited current clients (#1, #4, #5, #6, #7 and #9); failed to ensure counseling sessions were completed after a positive Urine Drug Screen (UDS) affecting five of twelve audited current clients (#1, #5, #6, #7 and #9) and failed to ensure dual enrollment was completed affecting one of twelve audited current clients (#3) and one of one audited deceased client (#13). The findings are: The following is evidence the facility staff failed to ensure clients attended at least one counseling	V 238		

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V 238	Continued From page 10 session per month. Review on 6/5/24 of client #1's record revealed: -Admission date of 1/24/23. -Diagnosis of Opioid Use Disorder. -There was no counseling session completed for April 2024. Review on 6/6/24 of client #4's record revealed: -Admission date of 9/5/19. -Diagnosis of Opioid Use Disorder -There was no counseling session completed for April 2024. Review on 6/6/24 of client #5's record revealed: -Admission date of 11/28/23. -Diagnosis of Opioid Use Disorder. -There was no counseling session completed for April 2024. Review on 6/6/24 of client #6's record revealed: -Admission date of 12/8/23. -Diagnosis of Opioid Use Disorder. -There was no counseling session completed for April 2024. Review on 6/6/24 of client #7's record revealed: -Admission date of 7/19/17. -Diagnosis of Opioid Use Disorder. -There was no counseling session completed for April 2024. Review on 6/6/24 of client #9's record revealed: -Admission date of 9/5/19. -Diagnosis of Opioid Use Disorder. -There were no counseling sessions completed for April and May 2024. The following is evidence the facility staff failed to ensure counseling sessions were completed after	V 238		

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V 238	Continued From page 11 a positive urine drug screen. Review on 6/5/24 of client #1's record revealed: -UDS completed on 5/21/24 and 4/1/24-he tested positive for Tetrahydrocannabinol (THC). -There were no counseling sessions completed by client #1's Counselor to address the positive UDS results. Review on 6/6/24 of client #5's record revealed: -UDS completed on 4/18/24-she tested positive for Amphetamine (AMPH) and Fentanyl. -There was no counseling session completed by client #5's Counselor to address the positive UDS results. Review on 6/6/24 of client #6's record revealed: -UDS completed on 4/18/24-she tested positive for THC. -There was no counseling session completed by client #6's Counselor to address the positive UDS results. Review on 6/6/24 of client #7's record revealed: -UDS completed on 4/5/24-she tested positive for THC. -There was no counseling session completed by client #7's Counselor to address the positive UDS results. Review on 6/6/24 of client #9's record revealed: -UDS completed on 5/23/24 and 4/9/24-he tested positive for Benzodiazepine (BZP) and Fentanyl. -There were no counseling sessions completed by client #9's Counselor to address the positive UDS results. The following is evidence the facility failed to complete dual enrollment.	V 238		

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V 238	Continued From page 12 Review on 6/6/24 of client #3's record revealed: -Admission date of 10/3/23. -Diagnosis of Opioid Use Disorder. -No documentation the dual enrollment was completed. Review on 6/6/24 of DC #13's record revealed: -Admission date of 1/23/24. -Diagnosis of Opioid Use Disorder. -He died on 4//4/24. -No documentation the dual enrollment was completed. Interviews on 6/5/24 and 6/6/24 with the Regional Clinical Supervisor revealed: -Counselor #1 was the only counselor working in April 2024 and that was the reason most of the clients had no April 2024 counseling sessions. -She and another Regional Director, other counselors for other clinics were helping out and doing caseloads as well. -Counselor #3 was client #1's Counselor. -Counselor #3 possibly did not realize she was supposed to do a counseling session for illicit drugs use. -They had been checking the client records to see if there were any missing documentation. -She wasn't sure why client #3 and DC #13 had no dual enrollment completed. -She confirmed facility staff failed to ensure counseling sessions were completed for clients #1, #4, #5, #6, #7 and #9. -She confirmed facility staff failed to ensure counseling sessions were completed after a positive urine drug screen for clients #1, #5, #6, #7 and #9. -She confirmed facility staff failed to ensure dual enrollment was completed for client #3 and DC #13.	V 238		

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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. (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;	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-165	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH COMPREHENSIVE TREATME	129 MAYO STREET HILLSBOROUGH, NC 27278

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V 536	Continued From page 14 (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 (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	V 536		

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V 536	Continued From page 15 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 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.	V 536		

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V 536	Continued From page 16 (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. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure three of six audited staff (the Medication Administration Licensed Practical Nurse (LPN), Counselor #1 and Counselor #2) had training on the use of alternatives to restrictive interventions. The findings are: Review on 6/5/24 of personnel records revealed: The Medication Administration LPN: -Date of hire was 4/11/24. -No documentation of training on the use of alternatives to restrictive interventions. Counselor #1: -Date of hire was 3/12/24. -No documentation of training on the use of alternatives to restrictive interventions.	V 536		

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V 536	Continued From page 17 Counselor #2: -Date of hire was 5/6/24. -No documentation of training on the use of alternatives to restrictive interventions. Interview on 6/5/24 with the Regional Clinical Supervisor revealed: -The agency uses Safety Care on the use of alternatives to restrictive interventions. -She knew some of the staff had no training in Safety Care. -The training was not done because they had an unexpected staff death. -Some of the staff were "traumatized" because they witnessed the incident and the staff person "basically died at the clinic." -They decided to "push back" the Safety Care training. -She confirmed there was no documentation of training on the use of alternatives to restrictive interventions for the Medication Administration LPN, Counselor #1 and Counselor #2.	V 536		