AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 06/26/2024	
		MHL096-186				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE			
CAROLIN	NA TREATMENT CEN		ST ASH STREI BORO, NC 275	ET, SUITE 200, 201, 202 & 300 330)	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLET DATE
V 000		те	V 000	DEFICIENCY)		
v 000	INITIAL COMMEN	15	V 000			
	An annual, follow up and complaint survey was completed on June 26, 2024. The complaint was unsubstantiated (Intake # NC00217252). A deficiency was cited.					
		sed for the following service C 27G .3600 Outpatient				
		current census of 498. The sisted of audits of 24 current				
V 235	27G .3603 (A-C) O	utpt. Opiod Tx Staff	V 235			
	counselor or certific to each 50 clients a on the staff of the f this prescribed ratio individual who is ce unavailability of cer hiring area, then it in person, provided th certification require months from the da (b) Each facility sh member on duty tra (1) drug abus (2) symptom to drug addiction. (c) Each direct car continuing education the following:	one certified drug abuse ed substance abuse counselor and increment thereof shall be acility. If the facility falls below o, 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 ements within a maximum of 26				
	(2) the withdi(3) group and	raudiction, rawal syndrome; d family therapy; and b diseases including HIV,				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Division	of Health Service Re	egulation			I OTAMA I HOVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL096-186	B. WING		R 06/26/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAROLII	NA TREATMENT CEN		T ASH STRE ORO, NC 27	ET, SUITE 200, 201, 202 & 300 530		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 235	Continued From pa	ge 1	V 235			
	sexually transmitted	d diseases and TB.				
	Continued From page 1 sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a minimum of one certified drug abuse counselor (CDAC) or certified substance abuse counselor (CAC) to each 50 clients. The findings are: Review on 6/25/24 of the facility's client and staff census revealed: - Current client census was 498 - Counseling staff consisted of 5 counselors in addition to the Clinical Supervisor, the Clinical Manager & the Clinical Director Interview on 6/25/24 Counselor #1 reported: - Started a month ago - Had 57 clients on her caseload - Expected her caseload to increase because a counselor quit on 6/21/24 - The facility had 5 counselors and was short staffed Interview on 6/25/24 Counselor #5 reported: - Started as a counselor two weeks ago - Doesn't have a caseload yet - The facility should have 8 to 10 counselors, but they only had 5 counselors onsite - The facility was currently short staffed and some counselors had more than 50 clients on their caseload					
	calth Sonvice Pequilation					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL096-186	B. WING		R 06/26/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE, ZIP CODE				
CAROLII	NA TREATMENT CEN		ST ASH STREI ORO, NC 275	ET, SUITE 200, 201, 202 & 3 30	00		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
V 235	Continued From page 2		V 235				
	reported: - Started as a co - Had 70 clients - The facility was counselors with 1 o - Her caseload in counselor quit on 6 - Prior to 6/21/24 caseload Interview on 6/26/2 reported: - Had 70 clients - The facility was able to meet the ne - Was currently if fill the 4 open posit Interview on 6/26/2 reported: - Had 70 clients - The facility was - Clinical manag counselors by havin - The open count and she's currently - She anticipated onsite within the ne	 4 she had 60 clients on her 4 the Clinical Manager on her caseload s short staffed, but they were beds of the clients nterviewing for counselors to ions 4 the Clinical Director on her caseload s short staffed ement "eased"the burden on ng caseloads iselor positions were posted interviewing to fill the positions 					

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